

**Wisconsin Medicaid Program  
Inpatient Hospital State Plan  
Method and Standards For Determining Payment Rates  
With Amendments Effective July 1, 2008**

**\*\*\*\*\* TABLE OF CONTENTS \*\*\*\*\***

	<u>Page</u>
<b>1000 OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT.....</b>	<b>1</b>
<b>2000 STATUTORY BASIS .....</b>	<b>2</b>
<b>3000 DEFINITIONS .....</b>	<b>2</b>
<b>3500 DIFFERENCES IN RATE SETTING BETWEEN IN-STATE AND OUT-OF-STATE HOSPITALS .....</b>	<b>3</b>
Hospitals Located in Wisconsin	
Hospitals Not Located In Wisconsin and Border Status Hospitals	
 <b>4000 COST REPORTING .....</b>	 <b>4</b>
General	
Cost Report Due Date -- In-State Hospitals	
-- Major Border-Status Hospitals	
Gains and Losses of Depreciable Assets	
Allowed Capital Cost Upon Change of Ownership	
 <b>5000 DRG BASED PAYMENT SYSTEM for In-state Hospitals and Major Border Status Hospitals.....</b>	 <b>5</b>
5020 HOSPITALS COVERED BY DRG SYSTEM.....	5
5030 SERVICES COVERED BY DRG PAYMENTS.....	5
5040 PROFESSIONAL SERVICES EXCLUDED FROM DRG PAYMENTS .....	5
5100 STANDARDIZED DRG PAYMENT FACTORS.....	6
DRG Grouper	
DRG Weights	
DRG Weights for MDC 15, Mental Diseases and Disorders	
Standard DRG Group Rates	
5200 HOSPITAL-SPECIFIC DRG BASE RATE .....	8
Calculation Of Hospital-Specific DRG Base Rate, General .....	8
Wage Area Adjustment Index.....	8
Disproportionate Share Adjustment Percentage .....	11
Rural Hospital Adjustment Percentage.....	14
5300 OUTLIER PAYMENTS UNDER DRG PAYMENT SYSTEM .....	15
Cost Outliers.....	15
Length of Stay Outliers.....	17

	<u>Page</u>
5400 CAPITAL COSTS PAYMENT UNDER DRG PAYMENT SYSTEM .....	18
Calculation for Hospitals Located In Wisconsin	
Calculation for Major Border Status Hospital	
Exemption From Capital Reduction	
5500 DIRECT MEDICAL EDUCATION PAYMENT UNDER DRG PAYMENT SYSTEM.....	20
Calculation for Hospitals Located In Wisconsin	
5800 OTHER PROVISIONS RELATING TO DRG PAYMENTS .....	23
Medically unnecessary stays	Authority for recovery
WIPRO Review	WIPRO control numbers
Inappropriate inpatient admission	Transfers
Inappropriate discharge/readmission	Days awaiting placement
DRG validation review	IMD hospital transfers
Changes of ownership	HMO/PEI alternative payment
Outpatient services related to inpatient stay	
Obstetrical and newborn same day admission/discharge	
Cost report used for establishing rates for hospitals combining operations	
Provisions relating to organ transplants	
5900 REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS .....	25.1
<b>6000 HOSPITALS PAID UNDER PER DIEM RATE .....</b>	<b>26</b>
6200 PAYMENT RATES FOR STATE MENTAL HEALTH INSTITUTES .....	26
6300 CALCULATION METHODOLOGY FOR REHABILITATION HOSPITALS .....	26.2
6400 OTHER PROVISIONS RELATING TO PER DIEM RATE SYSTEM .....	28
Medically unnecessary days, defined	Authority for recovery
Calculation of recoupment	WIPRO review
WIPRO control numbers	Inappropriate
inpatient admission	
Days awaiting placement	Temporary hospital
transfers	
Outpatient services related to inpatient stay	Changes of ownership
HMO/PEI alternative payment	
Cost report used for establishing rates for hospitals combining operations	
<b>7000 SERVICES EXEMPTED FROM THE DRG PAYMENT .....</b>	<b>29</b>
7100 PAYMENT FOR ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS).....	29
7200 PAYMENT FOR VENTILATOR-ASSISTED PATIENTS.....	30
7400 NEGOTIATED PAYMENTS FOR UNUSUAL CASES.....	31
7500 BRAIN INJURY CARE.....	31
7900 PAYMENT RATES FOR SERVICES EXEMPTED FROM DRG PAYMENT SYSTEM.....	32
<b>8000 FUNDING OF MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS .....</b>	<b>33</b>
<b>8100 SUPPLEMENTAL PAYMENTS FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH) .....</b>	<b>33.1</b>
<b>8200 GENERAL ASSISTANCE DISPROPORTIONATE SHARE HOSPITAL ALLOWANCE .....</b>	<b>33.2</b>
<b>8400 SUPPLEMENTAL PAYMENT FOR MAJOR MANAGED CARE HOSPITAL PROVIDERS (Not in Milwaukee County) .....</b>	<b>33.6.b</b>
<b>8500 PEDIATRIC INPATIENT SUPPLEMENT.....</b>	<b>33.6.c</b>
<b>9000 PAYMENT NOT TO EXCEED CHARGES.....</b>	<b>33.6.c</b>
<b>9100 LIMIT ON AMOUNT OF DISPROPORTIONATE SHARE PAYMENT TO A HOSPITAL.....</b>	<b>33.7</b>

	<u>Page</u>
<b>10000 PAYMENT OF OUT-OF-STATE MINOR BORDER STATUS &amp; NON-BORDER STATUS HOSPITALS</b>	<b>34</b>
10200 DRG BASED PAYMENT SYSTEM	34
Base DRG Rate	
Wage Area Adjustment Index	
Capital Cost Payment	
Payment for Psychiatric Stays	
Cost Outliers	
10300 PAYMENT NOT TO EXCEED CHARGES	35
10400 ADMINISTRATIVE ADJUSTMENT ACTIONS	35
Reduced Payment Possible	
Request Due Date and Adjustment Effective Date	
Effective Period	
10460 CRITERIA FOR ADMINISTRATIVE ADJUSTMENTS	36
For Minor Border Status and Non-border Status Hospitals	
Adjustment for being a hospital institution for mental disease (IMD)	
Adjustment of capital cost payment	
Disproportionate share adjustment applied to payments	
Adjustment of cost outlier tripoint for hospitals under 100 beds	
Facility-specific cost-to-charge ratio for use in outlier payment calculation	
Correcting adjustment due to inappropriate calculation of adjustments	
Per Diem Rate for Out-of-State Rehabilitation Hospitals	
10600 OUT-OF-STATE HOSPITAL RATES, STANDARDIZED AMOUNTS	38
<b>11000 ADMINISTRATIVE ADJUSTMENT ACTIONS For In-State and Major Border Status Hospitals</b>	<b>39</b>
Hospital's Submission of Request for Adjustment	39
Due Date of Request and Effective Date of Adjustment	40
Initiation of Adjustment by Department	40
Reduced Payment Possible	40
Withdrawal	40
Effective Period of an Administrative Adjustment	40
The 60 Day Rule	40
Definition, "Delivery date"	
Definition, "Final rate notification"	
Requested by Hospital Within 60 Days After Rate Notification	
Requested by Hospital After 60 Days From Rate Notification	
Requested by Hospital Before New Rate Year Begins	
..... Administrative Adjustments Initiated by the Department	
Correction of Inappropriate Calculations	

	<u>Page</u>
<b>11900 CRITERIA FOR ADMINISTRATIVE ADJUSTMENT ACTIONS .....</b>	<b>42.1</b>
For in-state and major border-status hospitals	
A. Correction of Inappropriate Calculation of Rates .....	42.1
B. Use More Current Cost Report If Available Cost Report Is More Than 3 Years Old.....	43
C Capital Payment Adjustment for Major Capitalized Expenditures, Eff January 1, 1996 .....	43.1
 D Adjustment for Changes in Medical Education, Effective July 1, 2003 .....	 43.2
 F. Reclassification of Hospital to Different Wage Area.....	 43.3
 I. Adjustment for PEI Ceasing to be Mandatory .....	 43.5
K. Eligibility for Rural Adjustment Considering Days Provided Under Out-of-State Medicaid Programs and/or Other Governmental Programs .....	 43.5
L. Adjustment to Rural Adjust Percent for Substantial Increase in Medicaid Utilization .....	43.6
M. Adjustment to Rural Adjust Percent for Recognition of Out-of-State Medicaid Days .....	43.6
N. Recalculation of DSH Cost Limitation of '9100 With Additional Information .....	43.7
O. Recalc of DSH Cost Limit of '9100 Upon Settlement of Outpatient Reimbursement.....	43.7
P. Claim Adjustment For Length Of Stay Outlier.....	43.7
Q. Adjustment For Hospital Expecting Payment To Exceed Charges.....	43.7
R. Disproportionate Share Adjustment for New Hospital.....	43.8
S. Adjustment for Combining Hospitals.....	43.8
 <b>APPENDICES</b>	
21000 Listing Of Hospitals Exempt From Capital Reduction.....	45
22000 Example Calculation - Hospital Specific DRG Base Rate.....	46
23000 Example Calculation - Hospital Specific Base Capital Payment .....	47
24000 Example Calculation - Hospital Specific Base Direct Medical Education Payment.....	48
24500 Example Calculation - Cost Outlier Payment.....	49
27000 Area Wage Indices .....	50
27100 Disproportionate Share Adjustment Amounts.....	51
27200 Inflation Rate Multipliers for Administrative Adjustments .....	52
28000 Policies and Procedures for Administrative Adjustment .....	55
 <b>End of Hospital Inpatient State Plan.....</b>	 <b>57</b>

**Wisconsin Medicaid Program  
Inpatient Hospital State Plan  
Method and Standards For Determining Payment Rates**

**SECTION 1000  
OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT**

This section is a brief overview of how reimbursement to hospitals is determined for inpatient services that are provided by hospitals to eligible recipients of the Wisconsin Medicaid Program (WMP). The WMP uses a reimbursement system which is based on Diagnosis Related Groupings (DRGs). The DRG system covers acute care hospitals and hospital institutions for mental disease (IMDs). Excluded from the DRG system are rehabilitation hospitals and State Institutions for Mental Disease (IMDs), which are reimbursed at rates per diem. Also, reimbursement for certain specialized services are exempted from the DRG system. These include acquired immunodeficiency syndrome (AIDS), ventilator-assisted patients, unusual cases and brain injury cases. Special provisions for payment of each of these DRG exempted services are included in the plan. As of July 1, 1995, organ transplants are covered by the DRG system.

The WMP DRG reimbursement system uses the grouper that has been developed for and used by Medicare, with enhancements for certain perinatal, newborn and psychiatric cases. The grouper is a computer software system that classifies a patient's hospital stay into an established diagnosis related group (DRG) based on the diagnosis of and procedures provided the patient. The WMP applies the Medicare grouper and its enhancements to Wisconsin-specific claims data to establish a relative weight for each of over 550 DRGs based on statewide average hospital costs. These weights are intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with a DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with a weight of 1.0, while a hospital stay assigned a DRG with a weight of .5 would require half the resources.

Each hospital is assigned a unique "hospital-specific DRG base rate". This hospital-specific DRG base rate includes an adjustment for differences in wage levels between rural and metropolitan areas throughout the state. This rate also includes an amount, based on the hospital's historical costs, for capital cost and for direct costs of medical education programs. For some hospitals, the rate also includes additional amounts for a serving a disproportionate share of low-income persons or for the hospital being located in a rural area.

Given a hospital's specific DRG rate and the weight for the DRG into which a stay is classified by the grouper, payment to the hospital for the stay is determined in multiplying the hospital's rate by the DRG weight.

A "cost outlier" payment is made when the cost of providing a service exceeds a pre-determined "trimpoint". Each inpatient hospital claim is tested to determine whether the claim qualifies for a cost outlier payment. A length-of-stay outlier payment is available upon a hospital's request for children under six years of age in disproportionate share hospitals and for children under age one in all hospitals.

For additional information, contact:

Hospital Rate Setting Section  
Division of Health Care Access and  
Accountability  
1 W. Wilson Street, Room 350  
P. O. Box 309  
Madison, Wisconsin 53701-0309.

Telephone (608) 266-9438  
FAX Telephone (608) 266-1096  
Voice/TDD 1-800-362-3002

## SECTION 2000 STATUTORY BASIS

The Wisconsin inpatient hospital payment system is designed to promote the objectives of the State statutes regarding payment for hospital services (Chapter 49, Wis. Stats) and to meet the criteria for Title XIX hospital payment systems contained in the Federal Social Security Act and Federal Regulations (Title 42 CFR, Subpart C). The inpatient payment system will comply with all applicable Federal and State laws and regulations and will reflect all adjustments required under these laws and regulations.

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## SECTION 3000 DEFINITIONS

**Annual Rate Update.** The process of annually adjusting hospital payment rates to be effective July 1 of each year based on more current cost reports and/or other information relevant to hospital reimbursement.

**Border Status Hospital.** A hospital not located in Wisconsin which has been certified by the WMAP as a border-status hospital to provide hospital services to WMAP recipients. (Reference, HFS 105.48, Wis.Adm.Code) Border status hospitals are differentiated between major providers and minor providers as described in section 3500.

**Children's Hospital.** Acute care hospital whose primary activity is to serve children.

**Department.** The Wisconsin Department of Health Services (or its agent); the State agency responsible for the administration of the Wisconsin Medical Assistance Program (WMAP).

**DRG.** DRG means Diagnosis Related Groups which is a patient classification system that reflects clinically similar groupings of services that can be expected to consume similar amounts of hospital resources.

**Hospital-Specific DRG Base Rate.** The payment rate per discharge which will be calculated for and assigned to each hospital by the Department for the rate year. This is the rate by which a DRG weight is multiplied to establish the amount of payment for an individual inpatient stay. Some provisions may allow this rate to change during the rate year.

**IMD.** Institution for Mental Disease, as defined in 42 CFR 435.1009. When used in this Plan, IMD means "hospital IMD".

**Long Term Care Hospital.** An acute care hospital reimbursed by Medicare under the Medicare prospective payment system for long-term care hospitals (LTCH).

**Medicaid Management Information System (MMIS).** The system used to process provider claims for payment.

**Non-Border Status Hospital.** A hospital not located in Wisconsin and which has not been certified by the WMAP as a border status hospital.

**Prospective Rate per Diem.** The hospital-specific rate for each day of service.

**Rate Year.** The twelve month period from July 1 through June 30 during which rates established under the annual rate update are to be effective for most, if not all, hospitals.

**SECTION 3000**  
**DEFINITIONS, continued**

*Rehabilitation Hospital.* A hospital that provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures, and multiple trauma to at least 75% of its patient population. IMD hospitals cannot be considered rehabilitation hospitals under the provisions of this plan.

*WMAP.* Wisconsin Medical Assistance Program, also referred to as Medicaid, Medical Assistance (MA) or Title XIX.

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**SECTION 3500**  
**DIFFERENCES IN RATE SETTING BETWEEN**  
**IN-STATE HOSPITALS AND OUT-OF-STATE HOSPITALS**

**3510 Hospitals Located in Wisconsin**

General hospitals and most specialty hospitals located in Wisconsin (in-state hospitals) are reimbursed according to the DRG based payment method described in section 5000 herein. All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000. As of July 1, 1995, organ transplants are paid under the DRG based payment method.

Certain specialty hospitals are reimbursed under a rate per diem methodology, not the DRG based payment system. Rehabilitation hospitals as defined in section 3000 are paid a per diem rate according to section 6300. The State's mental health institutes are paid under the payment rates described in section 6200. State operated hospitals which primarily service military veterans are paid under the payment rates described in section 6250.

*Administrative Adjustment of Rates.* In-state hospitals may request an administrative adjustment to their payment rates under the criteria described in section 11000. The due dates for requesting adjustments are described in that section.

*Use of Cost Report In Rate Setting.* An in-state hospital's audited cost report is required for establishing certain components of the hospital's specific payment. The specific components include the disproportionate share adjustment (§5240), the rural hospital adjustment (§5260), outlier payments (§4322), capital cost payments (§5420) and the direct medical education payments (§5520).

### 3520 Hospitals Not Located In Wisconsin and Border Status Hospitals

Hospitals not located in Wisconsin which provide inpatient services to WMAP recipients may be reimbursed for their services. Certain of these hospitals have been granted "border status" by the WMAP. Others do not have border status under the WMAP (non-border status hospitals).

*Non-Border Status Hospitals.* Out-of-state hospitals which *do not have border status* are reimbursed under the DRG based payment method described in section 10000 herein. Payment is based on a standard DRG base rate which does not recognize any hospital-specific differences such as capital costs, differences in wage areas and disproportionate share adjustments. A non-border status hospital may request an adjustment for many of these factors through the administrative adjustments described in section 10400.

All non-emergency services at out-of-state hospitals which do not have border status require prior authorization from the WMAP. This differs from the prior authorization requirements for in-state and border status hospitals.

*Minor Border Status Hospitals.* Border status hospitals are divided into minor and major border status hospitals. Minor border status hospitals are those border status hospitals which do not meet the criteria described below for a major border status hospital. Minor border status hospitals are reimbursed according to section 10000 in the same manner as non-border status hospitals and may request the administrative adjustments to payment rates as described in that section. A minor border status hospital is required to provide an audited cost report to the Department (see §4022).

*Major Border Status Hospitals.* Major border status hospitals are reimbursed according to the DRG based payment method described under section 5000. This is the same DRG method as is used for in-state hospitals. It provides a rate that takes into account hospital-specific costs for such as capital costs.

*Administrative Adjustments To Rates.* Major border status hospitals may request administrative adjustments to their payment rates under section 11000.

*Use of Cost Report In Rate Setting.* As described in section 4000, a major border status hospital must submit a current audited cost report to the Department for establishing certain components of their payment.

*Criteria For Major Border Status.* Major border status hospitals are those border status hospitals which have had 75 or more WMAP recipient discharges or at least \$ 350,000 or greater inpatient charges for services provided to WMAP recipients for the combined two rate years ending in the calendar years preceding the current annual rate update. Not included in these amounts are discharges and charges for: (1) Medicaid HMO covered stays, (2) stays which were paid in full or part by Medicare, (3) stays paid in full by a payor other than Medicare or Medicaid. Paid in full means the amount received by the hospital equals or exceeds the amount the WMAP would have paid for the stay. For each rate year, the Department will assess the discharges and charges of each border status hospital and notify the hospital of its standing as a major or minor border status hospital. For example, the following table shows the years used for a series of annual rate updates.

Annual Rate Update Effective Date	Rate Years Looked At for Discharges and Charges
July 1, 1996	July 1993 to June 1994 <u>and</u> July 1994 to June 1995
July 1, 1997	July 1994 to June 1995 <u>and</u> July 1995 to June 1996



### **3520 Hospitals Not Located In Wisconsin and Border Status Hospitals, continued**

*Rehabilitation Hospitals With Border Status.* A major border status hospital which the Department determines qualifies as a rehabilitation hospital, as defined in section 3000, will be reimbursed on a prospective rate per diem according to section 6300 otherwise the hospital will be paid under the DRG based payment method of section 5000. A minor border status rehabilitation hospital may request payment at a rate per diem according to section 10469.

*Alternative Payments To Border Status Hospitals For Certain Services .* For any out-of-state acute hospital, border status or not, all inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

## **SECTION 4000 COST REPORTING**

### **4010 General**

Every in-state hospital participating in the Wisconsin Medical Assistance Program (WMAP) will prepare a Title XIX cost report. The Wisconsin Medical Assistance Program uses the Medicare cost reporting form for its Title XIX cost report. Major border status hospitals will submit their audited Medicare cost reports. Hospitals will be instructed regarding any supplemental worksheets and additional information that may be specifically required by the WMAP.

### **4020 Cost Report Due Date**

#### **4021 In-State Hospitals.**

In-state hospital providers must submit their initial Medicare cost report and accompanying supplemental schedules to the Department or its agent at the same time it submits its initial Medicare (Title XVIII) cost report to its Medicare intermediary. When hospitals receive a notice of provider reimbursement (NPR) from Medicare or a Medicare audit intermediary, the hospitals must submit to the Department or its agent the Medicare cost report on which NPR is based. The Department's address for submitting cost reports is: Hospital Rate Setting Section, Division of Health Care Access and Accountability, P. O. Box 309, Madison, WI 53701-0309.

#### **4022 Major and Minor Border-Status Hospitals.**

Both major and minor border-status hospitals must submit Medicare audited cost reports to the Department within sixty (60) days of the Medicare audit being completed. A hospital not participating in the Medicare program should submit the cost report it provided the Medicaid program in its state. An audit should be considered completed upon the hospital receiving the Medicare audit report. If the hospital is pursuing any appeal of the audited Medicare cost report, the hospital should submit the audited cost report to the Department along with a description of the items being appealed. The Department's address for submitting cost reports is:

Hospital Rate Setting Section  
Division of Health Care Access and Accountability  
P.O. Box 309  
Madison, WI 53701-0309.

*Audited Cost Report Used In Rate Setting.* For major border-status hospitals, the Department uses a hospital's audited cost report on file with the Department to establish rates. If that cost report is for a fiscal year that is more than three years old, the hospital can request an administrative adjustment for use of a more current cost report in rate setting. Such an administrative adjustment is discussed under section 11900, item B.

**4050 Gains and Losses of Depreciable Assets**

Depreciable assets may be disposed of through donation, sale, scrapping, demolition, abandonment or involuntary conversion such as condemnation, fire, theft or other casualty. The gain or loss on such a disposition is not recognized for reimbursement under the Wisconsin Medicaid Program. This means that for dispositions occurring after June 30, 2004 the WMP will not recover a portion of any gains and will not provide supplemental payments for a portion of the losses.

Depreciable assets may be disposed of and replaced with depreciable assets through trade-in or exchange or, in the case of facilities and land improvement, demolition to clear land for use by or adjacent to replacement facilities. The gain or loss on such disposed assets is to be recognized in the capitalized cost of the replacement assets in accord with generally accepted accounting principals.

**4040 Allowed Capital Cost Upon Change of Ownership**

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a hospital which has undergone change of ownership, Medicare allowable cost principles now in effect or as may be amended govern the allowableness of costs except when provisions of this plan specifically describe a variance from Medicare principles.



**SECTION 5000**  
**DRG BASED PAYMENT SYSTEM**  
**FOR IN-STATE HOSPITALS AND MAJOR BORDER STATUS HOSPITALS**

**5010 INTRODUCTION**

A hospital is paid a prospectively established amount for each discharge under the DRG based payment system. In the Department's annual rate update, a "hospital-specific DRG base rate" is calculated for each hospital. This rate is the result of adjusting a "standard DRG group rate" for the wage area of each hospital. In addition, if the hospital qualifies, the rate includes disproportionate share (\$5240) or rural hospital adjustments (\$5260). As of July 1, 1997, the hospital-specific DRG base rate includes payment for capital costs (\$5400) and direct medical education costs (\$5500). As of July 1, 1999, the indirect and direct medical education costs are not included in out-of-state hospital-specific DRG base rates. As of July 1, 2003, an indirect medical education cost adjustment is not included in any hospital-specific DRG base rate.

For each Medicaid recipient's stay, a hospital's specific DRG base rate is multiplied by the relative weighting factor for the diagnosis related group (DRG) which applies to the hospital stay. The result is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high cost cases which are described in sections 5321 through 5324 or for certain very long lengths of stay which are described in sections 5331 through 5334.

**5020 HOSPITALS COVERED BY DRG SYSTEM**

Most general, specialty and IMD hospital providers in Wisconsin and most major border status hospitals will be paid according to the DRG based payment system described in this section 5000. Minor border status hospitals, out-of-state non-border status hospitals, rehabilitation hospitals, State operated IMD hospitals and veteran hospitals are not covered by this section 5000.

**5030 SERVICES COVERED BY DRG PAYMENTS**

All covered services provided during an inpatient stay, except professional services described in §5040, shall be considered hospital inpatient services for which payment is provided under this DRG based payment system. (Reference: Wis. Admin. Code, HFS 107.08(3) and (4))

All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

As of July 1, 1995, organ transplants are covered by the DRG based payment method.

#### 5040 PROFESSIONAL SERVICES EXCLUDED FROM DRG PAYMENTS

Certain professional and other services are excluded from the DRG payment system. Professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded, when the professionals are functioning in the capacity of:

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

#### 5100 STANDARDIZED DRG PAYMENT FACTORS

Certain standard factors are used in the determining the amount of payment hospitals receive for services covered by the DRG based payment method. The Department adjusts these standard factors for each rate year, July 1 through June 30. They include the DRG grouper and the DRG weights.

#### 5130 DRG Grouper

The DRG grouper is a patient classification software system which results in a patient stay being classified into one "diagnosis related group" (DRG). The WMP DRG reimbursement system uses the grouper developed for Medicare based on "major diagnostic categories" (MDCs). For newborns, WMP has enhanced the grouper's MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period. For psychiatric stays, the grouper's MDC 19, Mental Diseases and Disorders, is also enhanced.

Annually, beginning with July 1, 1992, updated versions of the Medicare grouper will be used by the WMP. The Medicare grouper version, which is released by CMS for use by Medicare beginning on October 1 of each calendar year, will be implemented for MA discharges occurring on and after July 1 of the subsequent calendar year. (For example, on October 1, 1991 CMS began to use Version IX of the Medicare grouper. Therefore, for dates of discharge on and after July 1, 1992, the WMP will apply that Version IX grouper.)

#### 5140 DRG Weights

DRG weights reflect the relative resource consumption of each inpatient stay. The weights are determined from an analysis of past services provided by hospitals, the claim charges for those services and the relative cost of those services. WMP recipient inpatient hospital claims are used in order that the weights which are developed are relevant to the types and scope of services provided to WMP recipients.

Annually, beginning with July 1, 1992, revised DRG weights will be established based on (1) the updated version of the Medicare grouper, (2) more current claims information and (3) more current inpatient hospital cost report information.

DRG weights in effect for the year July 1, 2005 through June 30, 2006 are applied in the rate year July 1, 2006 through June 30, 2007. Sections 5140.1 through 5140.3 are not applied for rate year July 1, 2006 through June 30, 2007.

*5140.1 Claims Used.* Claims for a period of at least three years for WMP certified hospital providers in Wisconsin are used. The selected period of claims is not to end more than twenty-four months nor less than nine months prior to the July 1st day on which the revised DRG weights are to be implemented. Claims not covered by WMP's DRG based payment system are not used. These are claims for which payment is made at rates determined under Sections 6000 and 7000. Also not used are claims from any hospital designated a critical access hospital (CAH) during the selected period of claims. This exclusion of claims applies to hospitals newly designated as a CAH or discontinued as a CAH anytime during the selected period of claims.

*5140.2 Cost Report Used.* The WMP uses the cost report for each hospital's most recently completed reporting period for which an audit adjusted cost report is available to the Department. as of the February 28th date prior to the July 1st day on which the revised DRG weights are to be implemented except the Department may, at its option, use audited cost reports it receives later. Costs are inflated as described below for the calculation of weights.

*5140.3 Weights Calculated.*

The updated version of the Medicare grouper described in section 5130 above is applied to the historical claims from the period described in subsection 5140.1 above. Each claim is classified to and assigned its appropriate diagnosis related grouping (DRG) by the grouper.

The cost of each inpatient hospital claim is calculated. This is a hospital-specific claim cost that requires correlating the services charged on the claim to related cost centers of the hospital's cost report.<sup>4</sup> For each claim, accommodation charges for the hospital stay are multiplied by the cost-to-charge ratio of accommodation cost centers in the respective hospital's cost report. The result is the cost of accommodations for the hospital stay. Ancillary service charges are multiplied by the cost-to-charge ratio of ancillary cost centers in the respective hospital's cost report providing a cost for ancillary services. Acquisition charges for transplanted organs are multiplied by cost-to-charge ratios for the respective organ. The resulting accommodation cost, ancillary service cost and organ acquisition costs of each claim is summed resulting in the total cost of the inpatient stay.

The cost of each inpatient stay is further standardized (or adjusted) for area wage differentials and reduced for the cost attributed to capital costs, direct medical education costs and outlier costs.

Each claim's cost is inflated by an inflation multiplier to the current rate year. The inflation multiplier is derived from indices in the publication, "Health-Care Cost Review", that is published quarterly by Global Insight, Inc. Specifically used are the total market basket indices from the tables entitled "CMS Hospital Prospective Reimbursement Market Basket."

The average cost of the claims by each DRG is calculated. Also, a combined overall average cost of all DRG claims is calculated. However, excluded from this overall average are claims grouped to MDC 15, Mental Disease and Disorders, for Milwaukee County Mental Health Center. The weight for each respective DRG is the average cost of the respective DRG's claims divided by the combined overall average cost. In this way, weights are established for over 550 DRGs.

Random anomalies and incongruities in the resulting weights are reviewed and analyzed in the light of the prior year weights and the cost and volume of claims involved. The questioned DRG weights are adjusted, if considered appropriate, to a reasonable amount based on the analysis. It should be noted that low-volume DRGs are especially vulnerable for significant year-to-year swings in their weight. A significant decrease in the weight of any individual DRG is limited unless cost, volume and central tendency and deviation data justify the significant decrease. A listing of the resulting proposed and final DRG weights are disseminated to in-state and major border status hospitals.

#### *5140.4 Cochlear Implants.*

A separate weighting factor is provided for inpatient hospital stays for cochlear implants. Payment is available upon written request by the hospital for payment at this weight and is only available for a claim that covers cochlear implant surgery and the cost of the apparatus. This is a low volume inpatient procedure for Medicaid recipients but is significantly more expensive than the broadly inclusive DRG #49, major head and neck procedures, in which cochlear implants are grouped (assigned). A claim for surgery without the apparatus cost will be covered under DRG #49. The cochlear implant weight was established based on the cost of 17 inpatient stays from February 1991 to August 1993. This set of claims covered some WMP recipients but mostly persons not covered by WMP. When a sufficient number of inpatient claims from a current period of no more than 7 years is available for WMP recipients receiving cochlear implants, a weight will be calculated based on those claims. The method of calculating a weight is that described above for other weights.

### **5140 DRG Weights For MDC 15, Mental Diseases and Disorders**

The WMP has expanded the nine standard diagnosis related groupings (DRGs) of MDC 15 for Mental Diseases and Disorders. For each of the DRGs, separate weighting factors are constructed for two age ranges: <sup>(1)</sup> over age 17 and <sup>(2)</sup> age 17 and younger. The result is 18 weighting factors. These weighting factors apply to hospital stays for mental diseases and disorders in acute care hospitals and in hospital institutions for mental disease (IMD) except Milwaukee County Mental Health Center.

As noted in subsection 5140.3, random anomalies and incongruities in the resulting weights are reviewed and adjustments made if considered appropriate.

### **5160 Standard DRG Group Rates**

A standard DRG group rate is the payment rate for a DRG weight of one (1.00) before providing any hospital-specific rate adjustments. Hospital-specific adjustments and allowances are applied to the standard DRG group rate to calculate each hospital's specific DRG base rate. Two separate group rates are used - one for acute care hospitals, another for hospital institutions for mental disease (IMDs).

Enrollment in the HMO Preferred Enrollment Initiative (PEI) has been mandatory for over ten years for Milwaukee County Medicaid recipients in certain medical status categories such as those for children and mothers. WMP recipients not mandated for HMO coverage are in general, but not limited to, aged and disabled. Because the non-HMO, fee-for-service Medicaid population in Milwaukee requires more intensive medical care and is more costly to care for than the fee-for-service Medicaid population in other counties, the standard DRG group rates will be 10% greater for Milwaukee County hospitals than for hospitals in other counties to allow for any HMO adverse selection occurring in Milwaukee. If the HMO/PEI ceases to be mandatory in Milwaukee County, the WMAP will eliminate the Milwaukee county-wide adverse selection adjustment from hospital-specific DRG base rates. A specific hospital may request an administrative adjustment under section 11900, item I, "Adjustment for PEI Ceasing to be Mandatory."

## **5200 HOSPITAL-SPECIFIC DRG BASE RATE**

### **5210 Calculation Of Hospital-Specific DRG Base Rate, General**

The "hospital-specific DRG base rates" is calculated as follows. Detailed descriptions of each element of the calculation follow this general description. An example of the calculation is in the appendix, section 22000.

The standard DRG group rate appropriate for the hospital is selected according to section 5160.

The labor portion of that group rate will be adjusted by the wage area index applicable to the hospital. The sum of the adjusted labor portion and non-labor portion is the total labor adjusted group rate. Section 5220 describes the wage area adjustment index.

The total labor adjusted group rate will be multiplied by the allowed adjustment percentage for each of the following adjustments for which the hospital may qualify: disproportionate share described in section 5240, rural location described in section 5260, and IMD hospital length of stay adjustment described in section 5270. Compound multiplication will be used, meaning that each successive product will be multiplied by the adjustment percentage added to one (1.00).

Added to this adjusted rate is a hospital's specific base payment for capital and a hospital's specific base payment for direct costs of a medical education program, described in sections 5400 and 5500.

The result is the "hospital-specific DRG base rate".

### **5220 Wage Area Adjustment Index**

#### **5221 Introduction.**

The standard DRG group rate applicable to a hospital will be adjusted by a wage area index. This subsection describes how the Department develops wage area indices and which index will be applied to a specific hospital. The wage area indices which are to be used for the current annual rate update are listed in appendix §27000.

#### **5222 Wage Area Classification.**

*Areas.* Wage areas are identified by the metropolitan statistical areas (MSAs) and the rural areas which are used by CMS in the Medicare program as of March 31 prior to the beginning of each rate year. These wage areas in Wisconsin are defined by the counties in each wage area. The Milwaukee MSA includes four counties. The Department has divided the Milwaukee MSA into two wage areas, a Milwaukee county only wage area and an Ozaukee-Washington-Waukesha counties' wage area.

*Reclassification.* A hospital is originally classified to the wage area in which it is physically located. However, if the Medicare Geographic Classification Review Board has reclassified a hospital to a wage area, other than the area of its physical location, the hospital may request the Department to recognize the reclassification for determining WMAP reimbursement rates. A written request for reclassification must be delivered to the Department by April 30 prior to the beginning of a new rate year. (For details, see administrative adjustment under section 11900, item F, "Adjustment to Hospital Wage Area".) For any hospital Medicare reclassified to the Milwaukee MSA, the Department will reclassify to the Ozaukee-Washington-Waukesha county wage area, not the Milwaukee county only wage area.

After all reclassifications are finalized for any rate year, hospitals in a wage area will be referred to as either,

- (1) "remaining original hospitals" which are hospitals physically located in the wage area and which have not been reclassified to or from the wage area, or
- (2) "reclassified hospitals" which are hospitals not physically located in the wage area but which have been reclassified to it.



**5223 Calculation of Wage Area Indices.** The Department will develop wage area indices based on hospital wage data available through the federal Centers for Medicare & Medicaid Services (CMS). Specifications identifying the CMS wage data used for the current rate year indices is identified in appendix 27000. For hospitals for which CMS has no data, such as childrens hospitals and IMDs, the Department may use data from other sources, if available. The developed indices will reflect the reclassification of hospitals out of a wage area and into another wage area.

Only wage data from hospitals certified as providers for the WMAP will be used. For determining indices for border status hospitals, both major and minor border status hospitals in each wage area will be used.

The following hospitals are not included in the calculation of wage indices.

- (1) Hospitals not covered by the DRG payment system (see section 5020).
- (2) Hospitals in Wisconsin designated as critical access hospitals as of September 30 immediately preceding the beginning of the rate year. For example, for the rate year beginning July 1, 2003, hospitals designated CAH as of September 30, 2002 are excluded.
- (3) Hospitals known to be closed or to have discontinued operating as a hospital as of September 30 immediately preceding the beginning of the rate year, not including hospitals combining or merging with another hospital.
- (4) Out-of-state hospitals which do not have border-status with the Wisconsin Medicaid program.

A statewide average wage rate will be calculated using wage data from WMAP certified hospitals located in Wisconsin. The average wage index for each wage area shall be the ratio of the average wage for the respective wage area to the statewide average wage. The statewide rate, in essence, has a 1.00 index. A wage area index of 1.05 means that the average wage rate for the area is 5% greater than the statewide average. A wage area index of .90 means that the area's average wage rate is 10% lesser than the statewide average.

The average statewide and area wage rates shall be the average of individual hospitals' average wage weighted by the individual hospitals' amount of staff. As a result, larger hospitals will have a greater impact on the statewide and area average wage rate than smaller hospitals.

For each wage area, three indices will be calculated:

- (1) a "composite" index which includes wages for the original remaining hospitals and the hospitals re-classified to the wage area,
- (2) an "original remaining hospitals" index based on wages of only the original remaining hospitals in a wage area, and
- (3) a "reclassified hospitals" index based on wages of only the hospitals reclassified to the wage area.

**5224 Determining Applicable Index.**

If the composite index is significantly lesser than the index for the original remaining hospitals in the wage area, then the index for the original remaining hospitals will be applied only to the originally remaining hospitals in the wage area. The reclassified hospitals' index will be applied only to hospitals reclassified to the wage area.

If the composite index for a wage area is not significantly lesser than the index for original remaining hospitals in the wage area, then the composite index shall be applied to both the original remaining hospitals and the hospitals reclassified to the wage area.

Significantly lesser means the composite index for a wage area is lower than the index of original remaining hospitals in the wage area by an amount exceeding one-percent (1%) of the index for the original remaining hospitals in the wage area.

The index applied to any hospital located in Wisconsin shall not be lesser than the rural Wisconsin index as determined under section 5225.

**5225 Rural Wage Area Indices.**

The wage index for the Wisconsin rural area will be based on wage data for only the original remaining hospitals in the rural area and will not include hospitals reclassified from or to the Wisconsin rural area. The wage index for the rural areas of other states will be based on wage data for only the original remaining hospitals in the rural area which are WMAP border status hospitals.



**5226 Recision of Reclassification By Department.**

A hospital's reclassification shall be rescinded by the Department if and only if the wage area index to be applied to the reclassified hospital:

- (1) is lesser than the index to be applied to the original remaining hospitals in the hospital's area of physical location or,
- (2) is lesser than the rural hospital adjustment under section 5260 if the hospital is located in a rural wage area but was reclassified to an urban wage area.

The Department will place all such hospitals into the wage area of their physical location, recalculate wage area indices according to the methodology described in section 5223, and again determine the applicable indices according to section 5224.

**5227 Recision of Reclassification by Hospital.**

If the Department has approved a hospital's administrative adjustment request for reclassification to another wage area, the hospital may request recision of their reclassification through the administrative adjustment under section 11900, item F. The Department may accept such a recision request and place the hospital back into its wage area of physical location if, and only if, the wage area index applied under section 5224 to the requesting hospital, (1) is lesser than the index to be applied to the original remaining hospitals in the requesting hospital's area of physical location., and, (2) is lesser than the wage area index applied to the requesting hospital for its rate in effect on June 30th of the preceding rate year. A hospital must request recision within the time limit specified by the Department.

## **5240 Disproportionate Share Adjustment Percentage**

### **5241 General.**

The special payment adjustment described in this section 5240, specifically subsections 5241 through 5248, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

Rate adjustments are allocated to hospitals that provide a disproportionate share of services to Medicaid and low-income patients. A hospital may qualify for a disproportionate share adjustment if the hospital's Medicaid utilization rate is at least 1% and if either (1) the hospital's *Medicaid utilization rate* is at least one standard deviation above the mean Medicaid utilization rate for hospitals in the State, or (2) has a *low-income utilization rate* of more than 25%.

### **5242 Obstetrician Requirement.**

In order for a qualifying hospital to receive its adjustment, it must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetrical care to WMAP recipients. Hospitals may substitute any physician with staff privileges to perform obstetrical care and who has agreed to provide care to WMAP recipients. If a hospital serves patients predominantly under age 18, or if the hospital did not offer non-emergency obstetrical care as of December 21, 1987, it need not comply with this obstetrical requirement in order to receive the adjustment.

### **5243 Medicaid Utilization Method.**

A hospital with high Medicaid utilization may qualify for a disproportionate share hospital (DSH) adjustment. The DSH adjustment under this "Medicaid utilization method" is provided to hospitals in the Department's annual DRG rate update. A hospital's DSH adjustment is incorporated into the hospital's specific DRG base rate and ultimately into the payment a hospital receives for each Medicaid recipient's stay.

*Statewide Amounts Calculated:* The Department annually calculates a "Medicaid inpatient utilization rate" for each hospital in the state that receives Medicaid payments. This is M in the following formula. From the compilation of the individual hospital utilization rates, the statewide mean average and standard deviation from the mean are calculated. The mean rate plus the amount of one standard deviation is S in the following formula.

*Qualifying Hospital Under Medicaid Utilization Method:* A hospital qualifies for a DSH adjustment if its Medicaid inpatient utilization rate (M) is equal to or greater than the mean-plus-one-standard-deviation (S) and is at least 1%.

*Hospital Specific Adjustment Calculated:* A "DSH adjustment percentage" is calculated according to the following formula for a hospital that qualifies under the Medicaid utilization method.

$$[(M \text{ minus } S) \times F] + 3\% \quad \text{where:}$$

M = Hospital's Medicaid inpatient utilization rate  
S = Statewide mean-plus-one-standard-deviation  
F = Proportional increase factor

This adjustment factor will be applied to either the DRG base rate or per diem rate, depending on the method of payment Medicaid uses for the eligible hospital type. The amount of the DSH add-on shall be limited by budgetary restrictions as outlined in section 5184.

*Adjustment for Certain IMDs.* The above 3% factor is increased to 11% for any hospital institution for mental disease (IMD) which qualifies for a disproportionate share hospital adjustment and has an average length of stay that exceeds 35 days for Wisconsin Medicaid recipients. Any days of a Medicaid recipient's stay that are covered in whole or part by Medicare are excluded from the calculation of the average length of stay. The average length of stay is based on the rate year that ended in the calendar year preceding the calendar year in which the current rate year begins. For example, for rates effective July 1, 1996, the base will be the rate year July 1, 1994 to June 30, 1995.

#### **5243 Medicaid Utilization Method, continued**

*Medicaid Inpatient Utilization Rate.* For purposes of the above calculation, the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for Medicaid, and the denominator of which is the total number of the hospital's inpatient days.

Medicaid inpatient days (the numerator) will include Medicaid HMO recipient days and recipient days of other states' Medicaid programs reported by a hospital.

Medical Assistance patient days in the numerator shall not include any days of inpatient stays which were covered in full or part by Medicare. Paid in full means the amount received by the hospital equals or exceeds the amount WMAP would have paid for the stay.

Some MA recipient stays, which are not covered in full or part by Medicare, may be paid fully or partially by a third party insurance payor and/or by a recipient's MA eligibility spend-down funds. If the hospital stay is paid in full, then the days of the recipient's stay will not be included in the numerator as an MA patient day. If the hospital is not paid in full and the WMAP reimburses the hospital for the unpaid balance, then all days of the stay will be included in the numerator as an MA patient day to the extent that the days of the stay were allowed by the WMAP.

*Base Data For In-State Hospitals.* For hospitals located in Wisconsin, the number of total inpatient days, MA inpatient days and MA HMO inpatient days will be from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update except the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. If the audited cost report which is used is more than three years old, the hospital may request an administrative adjustment under §11900, item B, to have its disproportionate share adjustment based on a more current audited cost report. The statewide mean Medicaid utilization rate and the standard deviation amount will not be recalculated to include the MA utilization rate resulting from the administrative adjustment. For the base cost reports to be used for hospitals combining operations, see section 5860.

The hospital must report recipient inpatient days of other state's Medicaid programs for the period of the audited cost report. For this, the hospital must submit auditable data acceptable to the Department by the April 30th prior to the annual rate update. This due date may be extended by the Department's notice to all Wisconsin hospitals.

*Base Data For Major Border Status Hospitals.* For major border status hospitals, the number of inpatient days shall be from the hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. The Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. Inpatient days of WMAP recipient stays will come from Department payment records. Cost reporting requirements are described in §4022. For cost reports to be used for combining hospitals, see §5860.

#### **5244 Low-Income Utilization Method.**

A hospital with a low-income utilization rate exceeding 25% may also qualify for a disproportionate share adjustment. A hospital has to specifically request the Department to be considered under this method for a disproportionate share adjustment. However, if a hospital qualifies for an adjustment under the Medicaid utilization method but requests an adjustment under the low-income method, the resulting lower adjustment percentage will be used. (See section 5246)

A hospital's "low income utilization rate" would be the sum of the following two percentages (next page), calculated as described on the next page. The Department will designate the cost reporting period.

**First Percentage.** Total payments from Medicaid to the hospital and total county general assistance program payments to the hospital for inpatient and outpatient services plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period. Revenues shall be net revenues after deducting bad debts, contractual allowances and discounts, that is, reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross. Revenues shall also exclude recorded charges for charity care.

**Second Percentage.** The total amount of the hospital's charges for inpatient hospital services attributable to charity care in a cost reporting period, less the portion of any cash subsidies described above in the period reasonably attributable to inpatient hospital services in the same period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period.

**Charity Care.** Charity care means health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. Charity care does not include any of the following: (1) care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care; (2) contractual adjustments in the provision of health care services below normal billed charges; (3) differences between a hospital's charges and payments received for health care services provided to the hospital's employees, to public employees or to prisoners; (4) hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy; or (5) bad debts. Bad debts means claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care.

**Adjustment Factors.** The following table lists the disproportionate share adjustment factor for each threshold percentage of the low-income utilization method.

<i>Low-Income Utilization Rate</i>	<i>Adjustment Percentage</i>
25.0% through 43.99%	3.0%
44.0% through 62.99%	3.5%
63.0% through 81.99%	4.0%
82.0% & greater	4.5%

The hospital has to provide auditable data acceptable to the Department which is necessary to calculate the above two percentages. For annual DRG rate updates effective on and after July 1, 1992, a hospital must submit auditable data acceptable to the Department by the end of the second month prior to the effective date of the annual rate update. (For example, for a July 1, 1995 rate update, the due date is April 30, 1995.) Data received after the due date may be excluded from determination of the disproportionate share adjustment.

#### **5246 Which Method Allowed.**

A hospital will only be allowed an adjustment either under the Medicaid utilization method of §5243 or under the low-income utilization method of §5244. If the Department determines a hospital qualifies for a disproportionate share adjustment under the Medicaid utilization method but the hospital requests an adjustment under the low-income method, the method which provides the lower disproportionate share adjustment percentage shall be used.

#### **5248 Public Notice.**

A listing of hospitals qualifying for an adjustment and the amount of the adjustment will be published in the Wisconsin Administrative Register.

## 5260 Rural Hospital Adjustment Percentage

### 5261 Qualifying Criteria.

A hospital may qualify for a rural hospital adjustment if it meets the following conditions. Administrative adjustments regarding qualifying for the rural hospital adjustment and the adjustment percentage are described in section 11900, items K, L, and M. Critical access hospitals under section 5900 are not eligible to receive an adjustment under this section.

1. The hospital is located in Wisconsin, is not located in a CMS defined metropolitan statistical area (MSA), and has the WMP's Wisconsin rural area wage index used in calculation of its hospital-specific DRG base rate.
2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare.
3. The hospital is not classified as a Rural Referral Center by Medicare.
4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics for the statistical years described below: (a) total discharges excluding newborns, (b) the Medicare case-mix index, and (c) the Wisconsin Medicaid case-mix index.
5. For rate years beginning on and after July 1, 1998, the combined Medicare and Medicaid utilization rate of the hospital is determined to be equal to or greater than 50.0%. For rate years beginning prior to July 1, 1998, the combined Medicare and Medicaid utilization rate has been equal to or greater than 55.0%.

For criteria item 1 above. The reclassification to an urban wage area, of a hospital which is located in a rural wage area, shall be rescinded by the Department if the urban wage area index to be applied to the hospital is lesser than the rural hospital adjustment. This allows the hospital to receive the urban wage adjustment or the rural hospital adjustment, whichever is greater. (Reference section 5226.)

For criteria item 4 above. The statistical year for total discharges excluding newborns will be the fiscal year of the hospital. The statistical year for the Wisconsin Medicaid case-mix index will be the state fiscal year. The statistical year for the Medicare case-mix index will be the federal fiscal year. The fiscal year to be used is that fiscal year which ended in the second calendar year preceding the annual July 1 rate update. (For example, for July 1, 1996 rate updates, the statistical years will be fiscal years that ended in 1994.) Urban hospital means any hospital located in Wisconsin which is located in a CMS defined metropolitan statistical area (MSA) or which has a WMAP urban area wage index used in calculation of its hospital-specific DRG base rate.

For criteria item 5 above. The combined Medicare and Medicaid utilization rate is determined by dividing the total Medicare and Medicaid inpatient days by the total inpatient days. Long-term care days from hospital swing-beds shall not be included as inpatient days in this calculation. The inpatient days will be from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. If the audited cost report which is used is more than three years old, the hospital may request an administrative adjustment under §11900, item B, to have its rural adjustment based on a more current audited cost report. For the base cost reports to be used for hospitals combining operations, see section 5860.

### 5262 Adjustment Percentage.

The amount of the rural hospital adjustment is based on a qualifying hospital's Medicaid utilization rate. The Medicaid utilization rate is determined by dividing the total Medicaid inpatient days by the total inpatient days from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. Long-term care days from hospital swing-beds shall not be included as inpatient days in the denominator of this calculation. The resulting Medicaid utilization rate is used to determine the adjustment percentage for the hospital-specific DRG base rate according to the table in appendix section 27300. The rural hospital adjustment percentage is that percentage corresponding to the range of utilization percentages in which the individual hospital's Medicaid utilization rate falls.





**5262 Adjustment Percentage, continued.**

*NOTE: To clarify for the federal Center for Medicare and Medicaid Services (CMS), the adjustment described in the above section 5260, specifically subsections 5261 and 5262, is NOT a disproportionate share hospital (DSH) adjustment under Section 1923 of the Social Security Act.*

**5300 OUTLIER PAYMENTS UNDER DRG PAYMENT SYSTEM**

**5310 General**

An outlier payment to the hospital provides a measure of relief from the financial burden presented by extremely high cost cases. It is an amount paid on an individual stay in addition to the DRG payment.

Cost based outlier adjustments and length-of-stay based outlier adjustments are provided. Each is described in detail below. If a hospital's claim qualifies under both the cost outlier and the length of stay outlier methods, then the Department shall pay under the method which gives the greater amount to the hospital.

The Department may evaluate the medical necessity of services provided and appropriateness of length of stay for all outlier cases prior to the issuance of outlier payments or, if payment has been made, recoup the same.

**5320 Cost Outliers**

**5321 Qualifying Criteria for a Cost Outlier Payment.**

For a hospital's claim to qualify for cost outlier payment, the following criteria apply:

1. The charges for a given case must be usual and customary.
2. The services provided must be medically necessary and the level of care appropriate to the medical needs of the patient.
3. The claim's cost, that is, charges-adjusted-to-cost, must exceed the DRG payment by the amount of the trimpoint applicable to the hospital. The applicable trimpoint will depend on the type and size of the hospital as follows for discharges on and after July 1, 2008.

Type of Hospital / Bed Size	----- Trimpoint Amount -----	
	Less than 100 Beds	100 Beds or Greater
General Medical & Surgical Hospitals	\$5,235	\$31,410
Hospital Institutions for Mental Disease (IMDs)	\$5,460	\$31,633
Long Term Care Hospitals	\$24,450	\$24,450

4. Hospital stays for which payment is not provided under the DRG payment system do not qualify for outlier payment consideration. This includes, but is not necessarily limited to cases treated at rehabilitation hospitals and State-operated IMDs exempt from DRGs, cases treated at hospitals reimbursed on a percent-of-charges basis, and cases for services exempted from DRG payment system under section 7000. Claims for chronic, stable ventilator-dependant hospital patients shall be reimbursed under the ventilator rate and, therefore, are not eligible for a cost outlier payment.

### **5322 Charges Adjusted-To-Cost.**

*For Wisconsin Hospitals.* For a hospital located in Wisconsin, claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for WMAP inpatient services. The cost-to-charges ratio to be used will be from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update except the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. For cost reports to be used for combining hospitals, see §5860.

For hospitals for which the Department does not have an audited cost report, the cost-to-charge ratio from the most recent unaudited cost report available to the Department will be used. This unaudited cost-to-charge ratio will be used until the Department gets an audited cost report.

If an audited and an unaudited cost report is not available, then the cost-to-charge ratio to be used for the specific hospital will be the average state-wide cost-to-charge ratio which is the ratio of the total state-wide inpatient hospital costs for WMAP services to the total charges for those services. This statewide mean will be used until the Department acquires a cost report from which, if unaudited, the cost-to-charge ratio will be used until the Department gets an audited cost report.

*For Major Border Status Hospitals.* For a border-status hospital, the Department shall determine a cost-to-charge ratio applicable to inpatient services provided Wisconsin Medicaid recipients by the hospital based on the hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months. Cost reporting requirements are described in §4022. For cost reports to be used for combining hospitals, see §5860.

If an audited and an unaudited cost report is not available, then the cost-to-charge ratio to be used for the specific hospital will be the average Wisconsin state-wide cost-to-charge ratio which is the ratio of the total Wisconsin state-wide inpatient hospital costs for WMAP services to the total charges for those services. This statewide mean will be used until the Department acquires a cost report from which, if unaudited, the cost-to-charge ratio will be used until the Department gets an audited cost report.

### **5323 Outlier Payment Calculation.**

Variable costs in excess of the DRG payment and the trimpoint will be paid. Following are the steps for calculation of an outlier payment. An example of a cost outlier calculation is presented in appendix section 24500.

1. Allowed claim charges are adjusted to cost by multiplying the charges by the hospital's cost-to-charge ratio.
2. The allowed excess claim costs will be calculated by subtracting the DRG payment and the hospital's trimpoint from the claim costs.  
  
(Claim cost - DRG payment - Trimpoint = Excess cost, must be positive to qualify).
3. The outlier payment will be the result of multiplying the excess claim costs by the variable cost factor of 77%. The variable cost factor for burn cases will be 97%. If the hospital is a disproportionate share hospital, the variable cost factor will be increased by 77% of the hospital's disproportionate share adjustment percentage.

#### **5324 Bed Count, Source and Changes.**

For rate years beginning on and after July 1, 1992, the trimpoint amount for each hospital shall be established effective July 1 of the rate year based on the bed count on file with the Department's Division of Quality Assurance, as of July 1 of the respective rate year. The hospital may request an administrative adjustment under section 11900, item A, to correct errors by the Department in establishing the appropriate trimpoint.

If a hospital changes its bed count after July 1, any change in the trimpoint amount will not be effective until July 1 of the subsequent rate year. The hospital must provide written notice of its change in bed count to the Division of Quality Assurance in sufficient time that the notice is received by the Bureau on or before July 1 of the rate year. The hospital should, but is not required to, provide a copy of the notice of the change to the Department's Division of Health Care Access and Accountability.

#### **5330 Length of Stay Outliers**

##### **5331 Qualifying Criteria.**

For a hospital's claim to qualify for length of stay outlier payment, the following criteria apply:

For disproportionate share qualifying hospitals (under section 5240):

1. The hospital qualified for a disproportionate share adjustment at any time during the period of the stay, and
2. The claim is for inpatient services for a child who was under six years of age on date of discharge, and
3. For discharges on and after July 1, 1994, the length of the child's stay exceeds 75 days (threshold days). (Prior to 7/1/94 the threshold was 114 days.)

For all hospitals:

1. The claim is for inpatient services for an infant who was under one year of age on date of discharge, and
2. For discharges on and after July 1, 1994, the length of the infant's stay exceeds 75 days (threshold days). (Prior to 7/1/94 the threshold was 114 days.)

##### **5333 Request for Length of Stay Outlier Payment.**

Under administrative adjustment P in §11900, a hospital may request a length of stay outlier payment. The hospital must submit a claim for the stay to the Department's fiscal agent. In addition, the hospital must submit a request for a length of stay outlier payment to the Department with a copy of the claim. The Department will determine if the claim qualifies for an adjustment and will calculate the amount of adjustment.

Hospitals should send requests for a length of stay outlier adjustment to:

Hospital Rate Setting Section  
Division of Health Care Access and Accountability  
P.O. Box 309  
Madison, WI 53701-0309.

**Due Date.** The request for this adjustment must be delivered to the Department within 180 days after the date the recipient is discharged from the hospital. This due date applies without regard as to whether or not a claim for the stay has been paid by the Department's fiscal agent.

#### **5334 Calculation of Length-of-Stay Outlier Payment.**

The claim charges will be adjusted to cost pursuant to paragraph 5320.2 above. The cost will be divided by the length of the stay to determine the cost per day. To calculate variable costs, the cost per day will be multiplied by 77% plus 77% of the disproportionate share percentage. The resulting variable cost per day will be multiplied by the number of days which exceed the threshold days to determine the outlier payment to be made.

If a hospital's claim qualifies under both the cost outlier and the length of stay outlier methods, then the Department shall pay under the method which gives the greater amount to the hospital.

### **5400 CAPITAL COSTS PAYMENT UNDER DRG PAYMENT SYSTEM**

#### **5410 General**

As of July 1, 1997, an amount for capital costs is added to a hospital's specific base DRG rate. For Wisconsin hospitals and major border status hospitals, this capital payment amount is prospectively established based on an individual hospital's past capital costs. Prior to July 1, 1997, the capital payment was prospectively determined and paid through a monthly payment without regard to the number of WMP recipient discharges during the month.

#### **5430 Calculation for Hospitals Located In Wisconsin**

*Base Cost Report.* The capital cost payment is determined from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months.

If the cost report on file is more than three years old, the hospital may request an administrative adjustment to the capital cost payment amount pursuant to section 11900, item B.

An administrative adjustment is provided in section 11900, item C, for major capital expenditures incurred after the beginning of the base cost reporting period.

For combining hospitals, section 5480 below describes the cost report to be used for calculating the capital payment.

*No Audited Cost Report Available.* For hospitals for which there is no audited cost report available, an estimated capital payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The capital payment will be adjusted retrospectively when an audited cost report becomes available to the Department.

*Calculation.* The capital payment for a hospital located in Wisconsin is determined from cost information from each individual hospital's base cost report. An example calculation is in section 23000 of the appendix.

1. The capital cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient capital costs to total allowed inpatient costs. These amounts are readily identifiable in the base cost report.
2. The resulting WMP capital cost from step 1 is reduced by 5% except for a hospital qualifying for an exemption under section 5450.
3. The amount from step 2 is inflated through the rate year by the DRI/McGraw Hill, Inc. HCFA Hospital Market Basket inflation rate and increased by any disproportionate share adjustment percentage applicable to the individual hospital.

**5430 Calculation for Hospitals Located In Wisconsin, continued/**

4. The amount from step 3 is divided by the number of WMP recipient discharges for the period of the audited cost report.
5. The resulting amount per discharge is divided by the average DRG case mix index per discharge.
6. The result from step 5 is the hospital's specific base capital payment at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate described in section 5210.

**5440 Calculation for Major Border Status Hospitals**

*Base Cost Report.* For major border status hospitals, the capital cost payment is determined from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months. Cost reporting requirements are described in §4022. An administrative adjustment is provided in section 11900, item C, for major capital expenditures incurred after the beginning of the base cost reporting period.

For combining hospitals, section 5480 below describes the cost report to be used for calculating the capital payment.

*No Audited Cost Report Available.* For hospitals for which there is no audited cost report available, an estimated capital payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The capital payment will be adjusted retrospectively when an audited cost report becomes available to the Department.

*Calculation.* A capital payment for a major border status hospital is determined as described above for Wisconsin hospitals from cost information from each individual hospital's base cost report. For item 1, the Department determines "the inpatient cost attributable to WMAP recipient inpatients". The hospital may request an administrative adjustment under section 11900, item A, to correct for incomplete or incorrect data used in the Department's calculations. An example calculation is in section 23000 of the appendix.

**5450 Exemption From Capital Reduction of Section 5430, Item 2.**

Item 2 of above section 5430 specifies a percentage by which capital costs are reduced. In order to assure reasonable access to needed inpatient hospital services for WMAP recipients in rural areas, a Wisconsin hospital and a border status hospital which meet the following criteria is exempted from the capital reduction in their capital payment calculation. A list of hospitals qualifying for the exemption is in the appendix, section 21000.

To qualify for this exemption, a facility must be both outside a federally designated Metropolitan Statistical Area (MSA) and further than thirty minutes travel time from any other general acute care hospital. In determining thirty minutes travel time, the WMP will generally consider distances equal to or greater than 25 miles.

If the federal government makes a change in the designation of an MSA, which affects any hospital pursuant to this subdivision, the Department will recognize the change for the next annual rate update.

**5480 Cost Reports For Recent Hospital Combinings**

A “hospital combining” is the result of hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital’s operation or a substantial amount of another hospital’s physical plant. For combining hospitals for which there is not an audited cost report available for the combined operation, an estimated capital payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The capital payment will be adjusted retrospectively when an audited cost report for a full fiscal year of the combined operation becomes available to the Department. The capital payment adjustment is effective the first day of the month following the month in which the combination was consummated.



## **5500 DIRECT MEDICAL EDUCATION PAYMENT UNDER DRG PAYMENT SYSTEM**

### **5510 General**

As of July 1, 1997, an amount is added to a hospital's specific base DRG rate for costs of its direct medical education program. This payment amount is prospectively established based on an individual hospital's past direct costs of its medical education program. Prior to July 1, 1997, direct medical education program costs were paid under a prospectively determined monthly payment amount without regard to the number of WMP recipient discharges during the month.

### **5530 Calculation for Hospitals Located In Wisconsin**

**Base Cost Report.** For hospitals located in Wisconsin, the direct medical education payment is determined from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months.

If the cost report on file is more than three years old, the hospital may request an administrative adjustment to the direct medical education payment amount pursuant to §11900, item B.

Significant changes in a hospital's direct medical education program costs after the base cost reporting period may be considered pursuant to the available administrative adjustment under section 11900, item D.

For combining hospitals, section 5480 describes the cost report to be used for calculating the capital payment.

**No Audited Cost Report Available.** For hospitals located in Wisconsin for which there is no audited cost report available, an estimated direct medical education payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The direct medical education payment will be adjusted retrospectively when an audited cost report becomes available to the Department.

**Calculation.** The direct medical education payment for a hospital located in Wisconsin is determined from cost information from each individual hospital's base cost report. An example calculation is in section 24000 of the appendix.

1. The direct medical education cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient direct medical education costs to total allowed inpatient costs.
2. The resulting amount is inflated through the rate year by the DRI/McGraw Hill, Inc. CMS Hospital Market Basket inflation rate and increased by any disproportionate share adjustment percentage applicable to the individual hospital.
3. The resulting gross amount is divided by the number of WMP recipient discharges for the period of the audited cost report.
4. The resulting amount per discharge is divided by the average DRG case mix index per discharge. For rate year July 1, 2004 through June 30, 2005, the result is also multiplied by budget factor of 1.00.
5. The result is the hospital's specific base payment for its direct medical education program at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate described in section 5210.

Payment for a specific patient's stay is determined by multiplying the base payment amount by the DRG weighting factor for a specific patient's stay.



## **5800 OTHER PROVISIONS RELATING TO DRG PAYMENTS**

### **5810 Medically Unnecessary Stays, Defined**

Medically unnecessary stays are those stays that are not reasonably expected to improve the patient's condition, that are not for diagnostic study, or that do not require the intensive therapeutic services normally associated with inpatient care. (See EQRO review section below regarding criteria.)

### **5813 Authority For Recovery**

The Department will recover payments previously made or deny payments for medically unnecessary hospital stays and/or inappropriate services based on determinations by the Department, the External Quality Review Organization (EQRO) or other organizations under contract with the Department. The Department is required by federal law to monitor the medical necessity and appropriateness of services provided to WMAP recipients and payments made to providers of such services. Wisconsin statute, section 49.45(3)(f)2m, authorizes the Department to adopt criteria on medical necessity and appropriateness and to deny claims for services failing to meet these criteria.

### **5816 Review by External Quality Review Organization (EQRO)**

The Department has contracted with an External Quality Review Organization (EQRO) to review selected hospitalizations of WMAP recipients for medical necessity and appropriateness. The process to select those hospitalizations which are reviewed is approved by the Department. The EQRO review criteria are premised on objective clinical signs of patient illness and documentation that intensive hospital services were being provided. The EQRO review process represents a highly professional, clinically sound approach for assuring that hospital services are used only when medically necessary. EQRO criteria is approved by the federal Centers for Medicare and Medicaid Services. The review criteria and periodic updates to it are disseminated to all hospitals in the state.

### **5819 EQRO Control Number**

The hospital must contact EQRO and acquire a unique case-specific control number from the EQRO for each of the following types of inpatient admissions:

- urgent/emergent admissions to hospital IMDs for recipients under 21 years of age,
- medical elective admissions, and
- admissions for ambulatory/outpatient procedures identified by the Department as needing control numbers.

Payment of inpatient claims for these admissions will be denied if the claims do not include the required case-specific control number from the EQRO.

### **5823 Inappropriate Inpatient Admission**

Payment for inpatient care which could have been performed on an outpatient basis shall not exceed the facility's outpatient rate-per-visit paid under section 4.19B of the Medicaid Hospital State Plan. If payment has been made, the difference between the payment and the outpatient rate-per-visit will be recovered.

### **5326 Inappropriate Discharge And Readmission**

If the EQRO determines that it was medically inappropriate for a patient to have been discharged from a hospital and as a result, that patient needed to be readmitted to a hospital, no payment will be made for the first discharge. If payment has been made, it will be recouped.

### **5829 Transfers**

Patient transfers may be reviewed by the EQRO or the Department for medical necessity. If the transfer is determined to have been medically necessary, then both the transferring and the receiving hospital will be paid the full DRG amount for their discharge.

### **5836 Days Awaiting Placement**

Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. A DRG weighted discharge payment will not be adjusted for days a WMAP recipient patient awaited placement to an alternative living arrangement. If placement to a NF or an ICF-MR is delayed, not on the hospital's part, for completion of required pre-admission screening for mental illness and/or mental retardation (required under Subtitle C, Part 2 of PL 100-203, the Omnibus Budget Reconciliation Act of 1987), the hospital may request and receive a per diem payment for each allowed day identified as waiting placement due to the lack of the pre-admission screen. This payment shall be in addition to the DRG payment, not to exceed the estimated statewide average NF rate. Each allowed day awaiting placement must be adequately documented for review in the patient chart.

### **5839 DRG Validation Review**

As part of the EQRO review process, the information provided on the hospital claim are verified with the medical record documentation. This review may determine that the DRG initially assigned to the hospital stay was inappropriate. The Department may adjust DRG payment pursuant to the result of EQRO reviews and recover any overpayment which has been made.

### **5843 IMD Hospital Transfers**

An inpatient at an IMD may transfer to an acute care general hospital for a short term stay, then return to the IMD and eventually be discharged from the IMD. If the person's absence from the IMD is due to the person being an inpatient of one or more acute care hospitals for a period of three or less consecutive days, the IMD will not be paid a separate DRG discharge payment for the transfer to the acute care hospital. If the absence is for a period exceeding three consecutive days, the IMD will be paid a separate DRG discharge payment for the transfer to the acute care hospital. Three or less consecutive days means the patient is absent or on-leave from the IMD for three or less successive midnight census counts of the IMD.

The IMD will be eligible for a DRG based discharge payment upon the eventual discharge of the patient from the IMD. The acute care hospital, to which the patient was transferred, will be reimbursed for the medically necessary stay without regard to the patient's length of the stay in the acute care hospital. Any payment to the IMD for a person's inpatient stay is subject to the person being eligible for MA coverage for their stay in the IMD.

### **5846 Outpatient Services Related To Inpatient Stays**

Outpatient hospital claims for services provided to a recipient during an inpatient stay are considered part of the inpatient stay and will be denied. Emergency room services shall be considered part of the inpatient stay, not outpatient services, if the patient was admitted and counted in the midnight census. Outpatient or professional claims on the date of admission or discharge will be allowed if billed by a provider other than the admitting inpatient hospital.

#### **5849 Obstetrical And Newborn Same Day Admission/Discharge**

A hospital stay shall be considered an inpatient stay when a WMAP recipient is admitted to a hospital and delivers a baby, even if the mother and the baby are discharged on the date of admission and not included in the midnight census. This consideration applies to both the newborn infant and the mother and also applies in those instances when the recipient and/or newborn is transferred to another hospital.

#### **5853 Changes of Ownership**

Payment rates will not change solely as a result of a change of ownership. At the time of ownership change, the new owner will be assigned the hospital-specific DRG base rate, the capital payment and the direct medical education payment of the prior owner. Subsequent changes to the hospital-specific DRG base rate, the capital payment and direct medical education payment for the new owner will be determined as if no change in ownership had occurred, that is, the prior owner's cost reports will be used until the new owner's cost reports come due for use in the annual rate update.

#### **5856 HMO/PEI Alternative Payment**

The Department may establish a reimbursement methodology to pay hospitals directly for the inpatient care of AFDC recipients enrolled in health maintenance organizations in counties where the HMO Preferred Enrollment Initiative (PEI) is mandatory. This reimbursement shall be a prospective DRG, rate-per-discharge or rate-per-diem, depending on the type of hospital, based on MA HMO hospital costs deflated to the base year, adjusted and indexed for the authorized rate increases. The cost of this inpatient care shall be deducted from the HMO capitation rate paid to HMOs.

#### **5860 Cost Report Used For Recent Hospital Combinings**

Hospital combinings result from in-state or major border status hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. Data from the audited cost reports of each previous (i.e., before the combining) individual hospital will be combined to calculate the following components of the hospital payment rates which require the use of cost report data: (a) the disproportionate share hospital adjustment under section 5243, (b) the rural hospital adjustment under section 5260, and (c) the cost-to-charge ratio used for outlier payments under section 5220. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used for the subsequent July 1 annual rate update. Under section 11900, item S, the combined or absorbing hospital may request the administrative adjustment to have its payments retroactively adjusted based on its audited cost report when they become available. (For capital and medical education payments for combined hospitals, see §5230, §5430, §5440, §5530, and §5540.)

#### **5862 Provisions Relating to Organ Transplants**

*Prior Authorization and Criteria.* In order for a hospital to receive payment for transplant services, the following criteria must apply:

- a. The transplant must be performed at an institution approved by the WMAP for the type of transplant provided. A list of approved hospitals is available from the Division of Health Care Access and Accountability, P. O. Box 309, Madison, WI 53701-0309.
- b. The transplant must be prior authorized by the Department. Prior authorization requests must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.
- c. In order to include the acquisition costs in the allowable charges, and not have the "acquisition costs" deducted from the transplant payment rate, the hospital will have to provide assurance to the Department that organs are procured from an organ procurement organization.

*Organ Procurement.* Organs must be obtained in compliance with the requirements of federal and state statute and regulations.

**5862 Provisions Relating to Organ Transplants, continued**

*Transplant Log.* Hospitals which perform organ transplants must maintain a log for every organ transplant performed for a WMAP recipient (except bone marrow) indicating the organ procurement organization or agency or source of the organ and all costs associated with procurement. A copy of this log must be submitted along with the transplant hospital's Medicaid cost report, so that the WMAP may document compliance.

**5900 Reimbursement for Critical Access Hospitals**

Definition: A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by CMS, and is designated as a critical access hospital by the Department.

Critical access hospitals are reimbursed the lower of the hospital's allowable cost or charges for the services provided to Medicaid recipients.

If payments exceed costs, the Department will recover excess payments from the hospital.

If costs exceed interim payments, the Department will reimburse the hospital the amount by which a hospital's costs exceed payments.

The Department will calculate an interim discharge rate based on a hospital's most currently audited cost report. If no cost report is available, the best available data will be used to set an interim rate.

Interim reimbursement may be adjusted to minimize the expected amount of excess payments that will need to be recovered from a CAH or the amount of expected additional payments the Department will need to make to a CAH. A CAH may request an adjustment to its interim payments until a final cost settlement can be calculated. No more than two such adjustment requests will be recognized by the Department for any fiscal year of the hospital. Upon consultation with the Department, the hospital must provide the Department sufficient information so that the interim adjustment is a reasonable and reliable estimate of the final cost settlement. The Department may deny an adjustment that is not significant.

Total inpatient payments may not exceed charges as described in section 9000.

## **SECTION 6000 HOSPITALS PAID UNDER PER DIEM RATE**

### **6100 COVERED HOSPITALS**

Rehabilitation hospitals, state-operated IMD hospitals, and state operated veterans' hospitals will be paid under a rate per diem. Services described in section 7000 are exempted from reimbursement under this section if reimbursement is requested by and approved for the hospital according to section 7000.

### **6200 PAYMENT RATES FOR STATE MENTAL HEALTH INSTITUTES**

This section 6200 describes how hospital institutions for mental disease owned and operated by the State are reimbursed for services provided Medicaid recipients. Reimbursement for inpatient hospital services will be a final reimbursement settlement for each hospital's fiscal year based on the hospital's allowable cost incurred in its fiscal year. All services provided during an inpatient stay, except professional services described in section 6480, will be considered inpatient hospital services for which payment is provided. Professional services described in section 6480 may be include in the final reimbursement settlement if a waiver or variance is approved under the procedures described in section 6258.

#### **6210 Interim Rate Per Diem**

Patient stays in a hospital covered by this section will be paid at interim or temporary rates per diem until a final reimbursement settlement can be completed for the hospital's fiscal year. The interim rate effective in a rate year, July to June, will be based on the interim rate per diem paid on June 30 of the prior rate year excluding any disproportionate share adjustment of section 5240. (The rate paid on the June 30 prior to the effective date of this change in reimbursement methodology will be the base for the interim rate effective on the effective date of this change.) The June 30 rate will be adjusted by the inflation multiplier from section 27200 that is listed under the fiscal year end date that coincides with the above June 30 date. The result will be increased by any disproportionate share adjustment for which the hospital may qualify under section 5240. The resulting interim rate will be increased if the hospital justifies an adjustment based on its historical expenses or expected expenses. The Department may at any time decrease the interim rate if it determines federal upper payment limits may be exceeded.

#### **6220 Final Reimbursement Settlement**

After a hospital completes each of its fiscal years, a final reimbursement settlement will be completed for Medicaid inpatient services provided during the year. The allowable costs a hospital incurred for providing Medicaid inpatient services during its fiscal year will be determined from the hospital's audited Medicaid cost report for the fiscal year. Allowable costs will include the net direct costs of education activities incurred by the hospital as determined according to 42 CFR §413.85. Covered education activities include those allowed under §413.85 and approved residency programs, allowed under 42 CFR §413.86, in medicine, osteopathy, dentistry and podiatry.

A disproportionate share hospital (DSH) adjustment will be determined according to section 5240 if the hospital meets the qualifying criteria of that section. The DSH adjustment percentage will be applied to the allowable cost of Medicaid inpatient services for the fiscal year to determine the hospital's DSH payment. To calculate the adjustment percentage, the formulae and related fixed variables of section 5240, that were in effect on the July 1 date in the hospital's fiscal year, will be applied to the patient utilization incurred by the hospital in its fiscal year.

The final reimbursement settlement will take the following federal payment limits into consideration:

- Total final reimbursement may not exceed charges according to section 9000.
- Compliance with the federal upper payment limit of 42 CFR §447.272, also know as the Medicare upper-limit, will be retrospectively determined when the final settlement is determined. If necessary, final reimbursement will be reduced in order that this federal upper payment limit is not exceeded.
- The hospital's disproportionate share payment may not exceed the limits of section 9100 which will be determined based on the hospital's fiscal year cost report used for the final settlement.
- Disproportionate share payment in the final reimbursement will be reduced, if necessary, to not exceed the State's limitations on aggregate payments for disproportionate share hospitals under 42 CFR 447.297.

**6220 Final Reimbursement Settlement, continued**

If the total amount of final reimbursement, including DSH payment, for the hospital's fiscal year exceed the total interim payments for the year, then the difference will be paid to the facility. The difference will be recovered if the total final reimbursement, including DSH payment, is less than the total interim payments.

The above reimbursement methodology is being implemented effective on a date that might not be the beginning date of a covered hospital's fiscal year. That is, the first months of such a hospital's fiscal year will not be covered, while the latter months are covered by the cost settlement. In such a case, the hospital's Medicaid allowable cost for its full fiscal year will be prorated between the months not covered and months covered by this reimbursement methodology based on the number of Medicaid inpatient days in each period.



## **6300 CALCULATION METHODOLOGY FOR REHABILITATION HOSPITALS**

Section 6310 applies to established rehabilitation hospitals which are not considered new. Section 6320 applies to new rehabilitation hospitals for the period described in that section.

### **6310 Calculation of Per Diem Rates for Established Rehabilitation Hospitals**

The following is the methodology to be followed for calculating a per diem payment rate for rehabilitation hospitals which are not new rehabilitation hospitals.

- 1) The Medicaid allowable costs from the audited cost reports for the hospitals' three base cost reporting years shall be indexed to June 30th of the earliest year of the three years by the DRI/McGraw Hill, Inc. HCFA Hospital Market Basket inflation rate. The "three base cost reporting years" for a hospital shall be the hospital's fiscal years which ended in the second, third and fourth calendar years preceding the calendar year of each annual rate update (defined §3000). (For example, for a July 1, 1992 annual rate update, the three base cost reporting years are a hospital's fiscal years which ended in 1990, 1989 and 1988 with costs being indexed to June 30, 1988, the earliest year of the three base years.) If needed audited cost reports are not available prior to a new rate year in order to calculate the annual rate update, then an interim rate shall be established for the new rate year until the audited cost reports are available.
- 2) Divide the total direct medical education costs for the three years by the total hospital costs for the three years to get the average percentage of direct medical education costs.
- 3) Divide the total capital related costs for the three years by the total hospital costs for the three years to get the average percentage of capital costs.
- 4) Multiply the total Medicaid allowable costs (step 1) by the percentage of direct medical education costs (step 2) to arrive at Medicaid direct education costs.
- 5) Multiply the total Medicaid allowable costs (step 1) by the percentage of capital costs (step 3) to arrive at Medicaid capital costs.
- 6) Subtract the Medicaid education costs (step 4) and the Medicaid capital cost (step 5) from the total Medicaid costs (step 1).
- 7) Multiply the Medicaid capital costs (step 5) by . 95.
- 8) Add the Medicaid costs (step 6), the Medicaid direct medical education costs (step 4) and the reduced capital cost (step 7). This is the total adjusted Medicaid costs.
- 9) Divide the adjusted Medicaid costs (step 8) by the total Medicaid days from the three audited cost reports to get an adjusted Medicaid cost per diem.
- 10) Index the adjusted Medicaid cost per diem by the legislatively authorized increases through the current rate year and increase the per diem by the disproportionate share adjustment factor if applicable. The disproportionate share adjustment factor will be determined pursuant to section 5240.

### **6320 Rates for New Rehabilitation Hospitals**

The Department will establish payment rates for new rehabilitation hospitals under a method other than that described above until cost reports are available for application of the above methodology.



**6322 New Rehabilitation Hospital and Start-Up Period**

The start-up period for a new rehabilitation hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends the June 30th date following completion of the hospital's fourth full (12 month) fiscal year after the fiscal year in which the first WMAP recipient was admitted. (For example, a hospital's fiscal year ends each September. It admitted its first WMAP recipient on March 10, 1994. Its fourth full fiscal year after the admission ends September 30, 1998. The next rate year begins July 1, 1999. Therefore, the hospital's start-up period is March 10, 1994 through June 30, 1999.)

**6324 Rates for Start-Up Period**

The rates per diem to be paid during the start-up period shall be an average of the rates being paid to other rehabilitation hospitals in the state, not including rates being paid new rehabilitation hospitals during a start-up period. If a rate being paid to a rehabilitation hospital is adjusted as is called for in step 1 of §6310, the statewide average rate will be recalculated. The start-up rate being paid to a new rehabilitation hospital will be adjusted prospectively based on the recalculated statewide average rate without a retroactive payment adjustment.

In calculating the statewide average rate, any disproportionate share adjustments which are provided to the other rehabilitation hospitals will not be included. The new hospital may request an 'administrative adjustment action' for disproportionate share adjustments to be applied to its start-up rates. Section 6328 below describes the criteria for the administrative adjustment action.

**6326 Rates After Start-Up Period Ends**

Rates will be established according to the methodology described in §6310 above after the start-up period ends. Two base cost reporting periods, not three as called for in step 1 of §6310, will be used for establishing rates for the initial rate year after the start-up period. (A rate year is July 1 to June 30.) For the subsequent rate years, three base cost reporting periods will be used as is specified in §6310.

**6328 Administrative Adjustment Criteria for Disproportionate Share Adjustment for New Hospital**

A new rehabilitation hospital may request a disproportionate share (DSH) adjustment under administrative adjustment item R in section 11900. For its rates during the start-up period and the first rate year after the start-up period, this administrative adjustment allows DSH adjustments to be based on Medicaid inpatient day utilization for periods other than that specified in §5243.

## **6400 OTHER PROVISIONS RELATING TO PER DIEM RATE SYSTEM**

### **6410 Medically Unnecessary Days, Defined (Under Per Diem Rate System)**

Medically unnecessary days are those days that are not reasonably expected to improve the patient's condition, that are not for diagnostic study, or that do not require the intensive therapeutic services normally associated with inpatient care. (See EQRO review section below regarding criteria.)

### **6413 Authority For Recovery (Under Per Diem Rate System)**

The Department will recover payments previously made or deny payments for medically unnecessary hospital stays or days and/or inappropriate services based on determinations by the Department, the External Quality Review Organization (EQRO) or other organizations under contract with the Department. The Department is required by federal law to monitor the medical necessity and appropriateness of services provided to WMAP recipients and payments made to providers of such services. Wisconsin statute, section 49.45(3)(f)2m, authorizes the Department to adopt criteria on medical necessity and appropriateness and to deny claims for services failing to meet these criteria.

### **6414 Calculation Of Recoupment (Under Per Diem Rate System)**

The amount to be recouped for medically unnecessary stays or days is calculated by multiplying the rate per diem times the number of denied days, less any co-payment or third-party payment.

### **6416 Review by External Quality Review Organization (EQRO) .**

Section 5816 applies to hospitals under the per diem rate system.

### **6419 EQRO Control Numbers.**

Section 5819 applies to hospitals under the per diem rate system.

### **6423 Inappropriate Inpatient Admission.**

Section 5823 applies to hospitals having per diem rates.

### **6436 Days Awaiting Placement (Under Per Diem Rate System)**

Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. Payment under the prospective rate-per-diem will be adjusted for days a WMAP recipient patient is awaiting placement to an alternative living arrangement. For those days identified as awaiting placement, payment shall be adjusted to an amount not to exceed the statewide average skilled care per diem rate for nursing facilities (NFs). Each allowed day awaiting placement shall be documented through patient chart review and subject to criteria established by the WMAP. The amount to be recouped is calculated by subtracting the skilled care rate from the rate per diem and multiplying by the days awaiting placement. The amount to be recouped is also reduced by the applicable amount of co-pay and third-party liability (TPL) payments.

### **6443 Temporary Hospital Transfers (Under Per Diem Rate System)**

When an inpatient in a hospital paid under the prospective rate per diem system is transferred to an acute care general hospital and transferred back, no per diem payment shall be provided to the hospital for the days of absence. The acute care hospital, to which the patient temporarily transferred, will be reimbursed by the WMAP for the medically necessary stay.

### **6446 Outpatient Services Related to Inpatient Stay.**

Section 5846 applies to hospitals under the per diem rate system.

### **6453 Changes of Ownership**

Section 5353 5853 applies to hospitals under the per diem rate system.

**6456 HMO/PEI Alternative Payment.**

Section 5856 applies to hospitals under the per diem rate system.

**6460 Cost Report Used For for Recent Hospital Combinings (Under Per Diem Rate System)**

Hospital combinings result from in-state or major border status hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. Data from the audited cost reports of each previous individual hospital will be combined to calculate any per diem rate which requires the use of audited cost reports. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used in the subsequent July 1 annual rate update. Under section 11900, item S, the combined or absorbing hospital may request the administrative adjustment to have its payments retroactively adjusted based on its audited cost report when they become available.

**6470 SERVICES COVERED BY PER DIEM RATE PAYMENTS UNDER SECTION 6000**

All covered services provided during an inpatient stay, except professional services described in §6480, shall be considered hospital inpatient services for which per diem payment is provided under this section 6000.

(Reference: Wis. Admin. Code, HFS 107.08(3) and (4))

**6480 PROFESSIONAL SERVICES EXCLUDED FROM PER DIEM RATE PAYMENTS UNDER SECTION 6000**

Certain professional and other services are not covered by the per diem payment rates under this section 6000. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the per diem payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

**SECTION 7000**  
**SERVICES EXEMPTED FROM THE DRG PAYMENT SYSTEM**

**7100 PAYMENT FOR ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)**

**7110 AIDS Acute Care and AIDS Extended Care Rates of Payment.** (Rates listed in §7900)

The current payment rates per diem for AIDS acute care and for AIDS extended care are listed in section 7900. These per diem rates apply for in-state hospitals, major and minor border-status hospitals and non-border status hospitals.

Total payment is calculated as the sum of the acute care per diem times the number of approved acute care days plus the extended care per diem times the number of approved extended care days. Payment will not exceed total covered charges.

**7150 Patient Criteria For Approval To Receive AIDS Rate of Payment**

**7150.2 Acute Care.** Payment of the acute care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria apply:

- a. The patient must have an established diagnosis of AIDS.
- b. Clinical findings and other relevant medical information must substantiate the medical necessity and appropriateness of the hospitalization and its payment at the AIDS acute care rate.
- c. Medical record documentation supporting the medical necessity and appropriateness of acute inpatient care must be submitted with the request for approval.

Approval for the acute care per diem is granted for a specified period of time. If the patient still meets the intensity and severity criteria for acute care, the provider must submit a subsequent request for extension of the payment approval.

**7150.3 Extended Care.** Payment of the extended care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria must be met:

- a. The patient must have an established diagnosis of AIDS.
- b. The patient must be medically stable per discharge indicators appropriate for the system involved.
- c. The patient must require infection control procedures and isolation techniques.
- d. Reasonable attempts at securing alternative living situations that allow for correct infection control procedures and isolation techniques must have been unsuccessful and an appropriate plan of care and discharge plan must have been established.
- e. The degree of debilitation and amount of care required must equal or exceed the level of skilled nursing care provided in a nursing facility (NF).
- f. Sufficient documentation supporting these criteria must be submitted with the request for approval.

Approval for the extended care rate is granted for a specified period of time, after which if the patient still meets the intensity and severity criteria for extended care, the provider must submit a subsequent request for extension of the payment approval.

The progression of illness may require acute care services during the period established for extended care. Therefore, during an "extended care" period, the acute care payment rate will be approved for payment after the hospital has provided an acute level of care for at least five days and the WMAP determines the above acute care criteria are met.

**7160 No Outlier Payment and Administrative Adjustment.**

AIDS cases paid under the per diem rate of this section do not qualify for outlier payments. AIDS reimbursement rates are not subject to administrative adjustment.

**7170 If AIDS Exemption Discontinued**

In the event that the AIDS payment rate is discontinued, the Department is obligated to pay for services at the latest rate adjusted annually for inflation until alternative placement for these patients can be found. The hospital will provide care to these patients at this latest rate until such time that an alternative placement can be found.

**7200 PAYMENT FOR VENTILATOR-ASSISTED PATIENTS**

**7210 Rate of Payment** (Rates listed in §7900)

The per diem payment rate for long-term ventilator services is listed in section 7900. Hospitals are required to bill on a monthly basis. This rate applies to instate hospitals, major and minor border-status hospitals and non-border status hospitals.

**7250 Criteria For Approval To Receive Ventilator-Assistance Payment Rate**

**7250.2 Patient Criteria.** Payment of the ventilator-assistance rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP based on the following criteria. The request is to be submitted through the WMAP prior authorization (PA) process. If one or more of the following criteria are not met, payment of the ventilator-assistance rate may be approved by the WMAP if it is determined that payment of such rate to the hospital for the patient's stay is expected to be less costly than alternative ventilator assistance services.

- a. The patient must have been hospitalized continuously in one or more hospitals for at least thirty consecutive days;
- b. The ventilator-assisted patient must be in a medically stable condition requiring an inpatient level of care;
- c. Attempts at weaning the patient from the ventilator are inappropriate or must have failed;
- d. The ventilator-assisted patient must require ventilator assistance six or more hours per day;
- e. Home care must be an unacceptable alternative because of financial/economic hardship or because of the lack of adequate support system; and
- f. Nursing home placement must be inappropriate because of the high level or type of care required or non-availability.

**7250.3 Dedicated Unit Provisions.** If a hospital has a specialized nursing unit dedicated to the care of ventilator-assisted patients, the Department will allow the hospital to be reimbursed retroactive to the first day of the stay in the dedicated unit even if that date is prior to the date of approval for payment at the ventilator-assistance rate.

**7250.4 Transfers.** Hospitals will continue to be paid the ventilator rate when ventilator-assisted patients are transferred to acute care or intensive care units for complications associated with their ventilator dependency. Hospitals will be paid the prospective DRG rate for transfers and/or admissions to acute care settings for medical problems unrelated to their ventilator dependency, provided the acute care stay lasts more than five days.

**7260 No Outlier Payment and Administrative Adjustment.**

Claims for patients who are eligible for this exceptional payment rate cannot be reimbursed as outliers. The ventilator-assistance reimbursement rates is not subject to administrative adjustment.

**7270 Ventilator-Assistance Exemption Discontinued.**

In the event that the Department discontinues the ventilator-assisted payment rate, the Department is obligated to pay for services at the most current rate adjusted annually for inflation until such time as an alternate placement for patients is found. The hospital will continue to provide care to these patients at this rate until alternative placement is found.

**7400 NEGOTIATED PAYMENTS FOR UNUSUAL CASES**

Notwithstanding other reimbursement provisions of this plan, the Department may allow an alternative payment for non-experimental inpatient hospital services if the WMAP determines that all of the following requirements are met:

1. The services are either:
  - a. Necessary to prevent death of a recipient or
  - b. Life threatening impairment of the health of a recipient or
  - c. Grave and long lasting physical health impairment of a recipient or
  - b. Cost effective compared to an alternative service or alternative services.
2. At the time this plan was submitted, the service(s) as proposed:
  - a. Was not reasonably accessible for WMAP recipients; or
  - b. Had not been a WMAP approved service provided for the particular purpose(s) intended; or
  - c. Had not been a WMAP approved service provided under similar medical circumstances; or
  - d. Required performance in the hospital which, given the circumstances of the recipient's case, is the only feasible provider or one of the only feasible providers known to the WMAP.
3. Existing payment methods are inadequate to ensure access to the services proposed for the recipient.
4. All applicable prior authorization requirements are met.

This §7400 applies to in-state hospitals, major and minor border status hospitals, and out-of-state hospitals not having border status. Alternative payments made under this provision shall be set on a case by case basis and shall not exceed the hospital's charges.

Requests for alternative payments under this provision are to be made to the: Office of the State Medicaid Director, Division of Health Care Access and Accountability, 1 West Wilson Street, Suite 350, P.O. Box 309, Madison, WI 53701-0309 (telephone 608-266-2522 or FAX 608-266-1096).

Requests must be submitted prior to admission, during the hospital stay or not later than 180 days after the WMAP recipient's discharge from the requesting hospital in order for an alternative payment to apply, at the discretion of the WMAP, beginning with the admission date (if applicable prior authorization requirements have been met to allow retroactive payment).

## **7500 BRAIN INJURY CARE**

**7520 In-State and Border-Status Hospitals.** A rate per diem is provided for prior authorized care of MA recipients in a hospital's brain injury care program which has been approved by the WMAP. The hospital's brain injury care program must be approved by the WMAP and each recipient's participation in the program must be prior authorized by the WMAP. The criteria for approval of a program and for prior authorization of an MA recipient's participation in the program is available from the Division of Health Care Access and Accountability (see address, section 100, page 1).

Periodic payment will be made to the hospital at the applicable rate per diem specified below. After completion of the hospital's fiscal year, total payments at the rates per diem in effect for brain injury care of prior authorized MA recipient services during its fiscal year will be determined. These total payments will be compared to the hospital's charges for the services and to the hospital's audited cost of providing the services. If the total payments exceed the total charges or the total costs, whichever is lesser, then the excess amount of payments will be recovered from the hospital.

The rates per diem for brain injury care programs for in-state and major and minor border status-hospitals are listed in section 7900. The WMAP may determine and approve additional rates for brain-injury care programs which provide significantly different services than are provided in the types of programs listed in section 7900.

### **7540 Non-Border Status Hospitals.**

Out-of-state non-border status hospitals will be paid at 68% of charges for prior authorized stays for brain injury care.





## 7900 PAYMENT RATES FOR SERVICES EXEMPTED FROM DRG PAYMENT SYSTEM

These payment rates are established by applying the general payment rate increase provided by the state's biennial budget to the rate in effect for the prior rate year.

For Section	Services	Rate Per Diem		
		Effective July 1, 1996	Effective July 1, 1997	Effective July 1, 1998
7100	AIDS Acute Care.....	\$ 570	\$ 582	\$ 597
7100	AIDS Extended Care.....	\$ 314	\$ 321	\$ 329
7200	Long-Term Ventilator Services.....	\$ 444	\$ 453	\$ 465
7500	Brain Injury Care			
	Neurobehavioral Program Care.....	\$ 780	\$ 796	\$ 816
	Coma-Recovery Program Care.....	\$ 937	\$ 957	\$ 981

## 7990 SERVICES COVERED BY PAYMENT RATES IN SECTION 7900 ABOVE

All covered services provided during an inpatient stay, except professional services described in §7992, are considered hospital inpatient services for which payment is provided under the payment rates listed in section 7910 above. (Reference: Wis. Admin. Code, HFS 107.08(3) and (4))

## 7992 PROFESSIONAL SERVICES EXCLUDED FROM PAYMENT RATES IN SECTION 7910 ABOVE

Certain professional and other services are not covered by the payment rates listed in section 7910 above. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the above payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

## **SECTION 8000**

### **FUNDING OF INPATIENT MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS**

#### **8001 GENERAL INTRODUCTION**

This is referred to as deficit reduction funding and is an adjustment to prior year costs as defined in 45 CFR §95.4. This reimbursement is available for hospital fiscal years beginning on and after July 1, 2006 and is determined based on a hospital's cost report for its completed fiscal year.

#### **8010 QUALIFYING CRITERIA**

A hospital will qualify for deficit reduction funding if:

- (a) The hospital is an acute care general hospital operated by the State or a local government in Wisconsin.
- (b) It incurred a deficit from providing Medicaid inpatient services (described in §8020 below),
- (c) The governmental unit that operates the hospital certifies it has expended public funds to fund the deficit.

#### **8020 DEFICIT FROM PROVIDING MEDICAID INPATIENT SERVICES**

The deficit from providing inpatient services to Wisconsin Medicaid recipients, that is, the Medicaid deficit, is the amount by which cost exceeds the payment for the Medicaid inpatient hospital services. The cost of Medicaid inpatient services is identified from the hospital's audited cost report for the hospital's fiscal year under consideration for the deficit reduction. Payment above refers to the total of the reimbursement provided under the provisions of section 5000 and sections 8200 to 8500 of this Attachment 4.19-A of the State Plan for inpatient services for the respective fiscal year.

#### **8025 INTERIM PAYMENT, INTERIM RECONCILIATION, AND THE FINAL RECONCILIATION**

Wisconsin will identify the total amount of uncompensated Medicaid Fee-For-Service Inpatient (FFS) hospital costs as described in Section 8020 to determine interim Medicaid payments under this section until finalized hospital cost reports are available. For the payment year, the per diem costs for routine cost centers and cost to charge ratios for ancillary cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552), as filed with the Medicare Fiscal intermediary. The process for the Interim Medicaid Payment Calculation is as follows:

The following process is used to determine inpatient hospital costs:

##### **Step 1**

Total hospital costs are identified from Worksheet B Part I Column 27, line 25 through 58.02. Total hospital patient days for inpatient routine costs are identified from Worksheet S-3 Part I Column 6.

##### **Step 2**

The cost and total hospital patient days from Step 1 represent the total hospital costs and days for purposes of determining the cost to charge ratios for ancillary cost centers and a calculated per diem cost for routine cost centers.

##### **Step 3**

The hospital's total charges by cost center are identified from Worksheet C Part I Column 8.

## **8025 INTERIM PAYMENT, INTERIM RECONCILIATION, AND FINAL RECONCILIATION, cont.**

### **Step 4**

The total hospital charges are included on Worksheet C Part I Column 8 lines 25 through 58.02. Organ acquisition costs for organs transplanted to Medicaid recipients will be calculated by applying Worksheet D-6 cost data from the CMS 2552 form.

### **Step 5**

The state will calculate a per diem for each routine cost center. For each inpatient routine cost center a per diem cost is calculated by dividing total hospital costs from Step 1, Worksheet B Part I Column 27, line 25 through 26.06, divided by total days identified in Step 1 Worksheet S-3 Part I Column 6, line 12 multiplied by Medicaid hospital FFS days identified from MMIS records for the most recent completed state fiscal year ending June 30. Long term care cost centers are excluded from this process. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, is computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The state will calculate a cost to charge ratio for each ancillary cost center. For ancillary cost centers, a cost to charge ratio is calculated by dividing the total hospital costs from Step 2 by the total hospital charges from Step 4.

The hospital cost to charge ratios and per diem allocation determined through the above process (steps 1-5) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid FFS for the payment year are determined as follows:

### **Step 6**

To determine the inpatient hospital routine and ancillary cost center costs for the payment year, the hospital's projected Medicaid FFS inpatient charges by cost center are used. To project Medicaid hospital FFS charges as accurately as possible for the payment year, the projection will be based upon the hospital's actual experience of Medicaid FFS inpatient charges for the most recent 6-month period. The projected charges are multiplied by the CMS Hospital Market Basket inflation rate published by DRI. The projected charges are then multiplied by the cost to charge ratios from Step 5 for each respective ancillary cost center and the per diem cost is multiplied by the Medicaid hospital FFS inpatient days to determine the Medicaid FFS inpatient costs for each routine service cost center.

### **Step 7**

The Medicaid hospital FFS costs eligible to be reimbursed under this section are determined by adding the Medicaid FFS inpatient costs from Step 6, and subtracting estimated Medicaid FFS inpatient payments. The payment estimate will be based on the hospital's Medicaid FFS payment experience for the most recent 6-month period.

## **Interim Reconciliation**

The hospital costs determined through the methods described for the payment year are reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out except for the changes noted below:

### **Steps 1 – 5**

Hospital costs and charges and patient days from the as-filed CMS 2552 cost report are used.

### **Step 6**

Medicaid hospital FFS charges and inpatient days from MMIS paid claims data are used subject to provider reconciliation.

## **8025 INTERIM PAYMENT, INTERIM RECONCILIATION, AND THE FINAL RECONCILIATION, continued**

### **Step 7**

Medicaid hospital FFS payments subject to provider reconciliation are used.

### **Final Reconciliation**

Once the CMS 2552 cost report for the payment year has been finalized by the Medicare fiscal intermediary, reconciliation of the finalized amounts will be completed, including use of the Worksheet D apportionment process. In the final reconciliation, Medicaid FFS cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series including 1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS records for the completed state fiscal year ending June 30 to the per diem amount; 2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and 3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center. Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid.

### **8030 LIMITATIONS ON THE AMOUNT OF DEFICIT REDUCTION FUNDING**

The combined total of: (a) the deficit reduction funding, and (b) all other payments to the hospital for inpatient Medicaid services, will not exceed the hospital's total charges for the services for the settlement year. If necessary, the deficit reduction funding will be adjusted so the combined total payments do not exceed charges.

The aggregate deficit reduction funding provided hospitals under this section will not exceed the amount for which FFP is available under federal upper-payment limits at 42 CFR 447.272.

There can be no Medicaid fee-for-service deficit for inpatient hospital services used to calculate any Disproportionate Share Hospital (DSH) payment.

### **8035 PAYMENT IN EXCESS OF COST**

If hospital payments exceed hospital costs, the financial gain from MA payments or payments for the uninsured will be applied against the unrecovered cost of uninsured patients/MA shortfall.

### **8040 HOSPITAL MUST REQUEST FUNDING**

A hospital must apply to the Department for deficit funding under this section 8000. The request must specify the fiscal year for which the hospital has requested deficit funding. The Department will determine if a hospital qualifies for deficit funding.



**SECTION 8100**  
**SUPPLEMENTAL DISPROPORTIONATE SHARE HOSPITAL PAYMENTS**  
**FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH)**

The special payments described in this section 8100, specifically subsections 8110 through 8130, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

Supplemental disproportionate share hospital payments are provided for any hospital located in Wisconsin which meets the following criteria for an "essential access city hospital" (EACH).

**8110 Qualifying Criteria for EACH Disproportionate Share Hospital Supplement**

A hospital qualifies for an EACH supplement in the current rate year if in the current rate year the hospital qualifies for a disproportionate share hospital adjustment under section 5240 and if the hospital met the following criteria during the year July 1, 1995 through June 30, 1996.

- 1) The hospital is located in the inner city of a city of the first class in Wisconsin as identified by the following U.S. Postal Service Zip Code areas. As of July 1, 1997, the following contiguous U.S. Postal Service Zip Code areas identify one inner city area covered by this supplement: 53202, 53203, 53205, 53206, 53208, 53209, 53210, 53212, 53216 and 53233.
- 2) At least 30% of the hospital's Medicaid recipient inpatient stays are for Medicaid recipients who reside in an inner city zip code area listed above.
- 3) More than 30% of the hospital's total inpatient days are Medicaid covered inpatient days.
  - (a) including Medicaid HMO covered days and Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as hospitalization insurance.
  - (b) but not including days of Medicaid recipients' stays that are covered in full or part by Medicare.
- 4) The hospital is an acute care general hospital providing medical and surgical, neonatal ICU, emergency and obstetrical services.

**8115 Determination of EACH Disproportionate Share Hospital Supplement**

The EACH supplement is paid in a prospectively established monthly amount based on the past Medicaid utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming rate year. The total statewide funding for the EACH supplement is limited to the amount that is listed in Appendix Section 27100. This amount is distributed proportionately among qualifying hospitals based on Medicaid inpatient days of the qualifying hospitals.

A qualifying hospital's EACH supplement will be determined as follows:

$$\text{Hospital's Annual EACH Supplement} = \frac{\text{Medicaid days for hospital}}{\text{Sum of Medicaid days of qualifying hospitals}} \times \text{Statewide Annual Funding Listed in Appendix 27100}$$

The monthly amount is the above annual amount divided by 12 months.

Medicaid days are a hospital's total covered inpatient days for Medicaid recipients for the calendar year prior to the rate year for which the EACH supplement is being calculated. The days include Medicaid HMO covered days and Medicaid covered days on which Medicaid made no payment due to the days being covered by some other payer such as hospitalization insurance but do not include days of Medicaid recipient stays that are covered in full or part by Medicare.

### **8130 Sanction on Not Continuing To Meet Qualifying Criteria**

A hospital receiving an EACH supplement is expected to maintain its effort to serve MA recipients including recipients and residents in the inner city area. If the Department finds a hospital fails to meet the above qualifying criteria above for any three month period, then payment of the supplement will be discontinued for the hospital and payments made for the three month period will be recovered. If the hospital shows it subsequently meets the criteria for any three-month period, then the supplemental payment will be reinstated at, and retroactive payment made since, the beginning of the three-month period in which the criteria were again met. If any qualifying hospital is sanctioned in a rate year, the monthly supplement of other qualify hospitals will not be recalculated to redistribute the total annual funding for the EACH supplement.

## **SECTION 8200 GENERAL ASSISTANCE DISPROPORTIONATE SHARE HOSPITAL ALLOWANCE**

This is a separate DSH allotment for areas covered by an Indigent Care Agreement (ICA) for indigent care approved by the single state agency. The areas covered by an ICA must be within reasonable geographic proximity to the hospital receiving the ICA DSH payment. The ICA must be between the hospital and a general assistance medical program in the area. The ICA must stipulate that direct or indirect health care services be provided to low-income patients with special needs who are not covered under other public or private health care programs. No payment will be made under this section to any hospital with a contractual obligation to forward that payment to any entity.

To be eligible for DSH payments made under this section, hospitals must meet minimum federal requirements for Medicaid DSH payments and have an approved ICA in place.

### **8205 Introduction.**

If above ICA provisions are met, qualifying acute care hospitals located in major urban counties will receive a disproportionate share hospital (DSH) payment for providing a significant amount of services to low-income persons residing in those counties who are not eligible for Wisconsin Medicaid coverage. The county administered general assistance (GA) medical program identifies these low-income persons whenever they apply for general assistance from the county. The county determines a person's low-income status under financial income criteria similar to or more restrictive than eligibility income criteria for the Wisconsin Medicaid program (WMP). The county also tabulates charges for hospital services provided persons covered by the county's GA medical program and provides an annual report to the WMP. The WMP uses this information in its calculation of this DSH allowance. A major urban county is a county with 500,000 or more population.

The special payments described in this section 8200, specifically subsections 8210 through 8260, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

### **8210 Qualifying Criteria.**

If above ICA provisions are met, a hospital is a disproportionate share (DSH) hospital and qualifies for general assistance disproportionate share hospital payments (GA-DSH) if the hospital meets all the criteria below.

- a) The hospital meets the obstetrician requirements of §5242.
- b) The hospital has a Medicaid inpatient utilization rate of at least 1% determined under §5243.
- c) The hospital or its parent corporation has a contract with the county government to serve low-income persons covered by the county's general assistance program.
- d) The ICA provisions described in the first paragraph of this section 8200 are met.

For a hospital to qualify as a DSH hospital under this §8200, the hospital is not required to meet the qualifying criteria for DSH under §5240. In contrast, a hospital that qualifies as a DSH hospital under this §8200 can qualify for the DSH adjustment under §5240 if, and only if, the hospital meets the qualifying criteria of §5240.





### **8220 Amounts of GA-DSH Allotment and Payments**

The amount of the GA-DSH allotment, when combined with all other DSH payments under the Plan, shall not exceed the State DSH allotment for Wisconsin for the relevant fiscal year, as published by CMS pursuant to § 1923(f) of the Social Security Act [42 USC § 1396r-4(f)]. The Department will establish a methodology for distributing the GA-DSH allotment under this section among qualifying hospitals such that the amount of the GA-DSH payment to each hospital in any year, when combined with any other DSH payment to the hospital, results in a total DSH payment that is not greater than the hospital's uncompensated costs for that year as determined under § 1923(g)(1)(A) of the Social Security Act [42 USC § 1396r-4(g)(1)(A)] or less than the hospital's minimum payment adjustment under the tests set forth in § 1923(c) of the Social Security Act [42 USC § 1396r-4(c)].

The GA-DSH funding is distributed among qualifying hospitals.

First, total charges are tabulated for each respective hospital for inpatient and outpatient services provided persons eligible for a county GA program in the calendar year prior to the July 1 rate year (at the discretion of the Department and subject to available DSH funding, the Department may also include other uncompensated care and unreimbursed Medicaid costs from these GA-eligible hospitals).

Second, these charges are multiplied by a ratio of cost-to-charges of the respective hospital resulting in a hospital-specific GA service cost.

Third, the hospital-specific GA service cost of all qualifying hospitals is summed.

Fourth, the maximum GA-DSH funding divided by this sum of hospital-specific GA service costs results in a ratio of funding-to-costs.

Fifth, the ratio of funding-to-costs multiplied by the GA service cost of each qualifying hospital results in the annual GA-DSH allowance for each hospital and a proportional distribution of the GA-DSH funding among qualifying hospitals. The ratio of funding-to-costs is not to exceed 1.00 in order that the total of the GA-DSH allowances do not exceed total GA service costs of the qualifying hospitals.

Sixth, this annual amount is paid to the respective qualifying hospitals.

### **8230 Combining Historical Financial Statistics for Recent Hospital Combinings**

Hospital combinings result from hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant.

When hospitals combine into one hospital, the required years of historical data may not be available for the combined operation for one or more rate years after the combining occurs. Whenever a required year of data is available for a full year of the combined hospital operation, then that year of data is used. However, if a full year is not available for the combined operation, then data of the individual hospitals for the required years is combined or added together for the calculations under §8210 through §8250.

**SECTION 8400**  
**SUPPLEMENTAL PAYMENT FOR MAJOR MANAGED CARE HOSPITAL PROVIDERS**  
**Not in Milwaukee County**

Supplemental payments will be provided for any hospital located in Wisconsin which meets the qualifying criteria below. This supplement is only available to hospitals that are a major participant in the state's Medicaid managed care (that is, HMO) initiative. The payments will be subject to the payment limitation of \$9000 by which the total of the overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for services provided to Medicaid recipients.

**8410 Qualifying Criteria.**

A hospital will qualify for this supplemental payment for the rate year if:

- (1) qualifies for a disproportionate share adjustment under §5243,
- (2) more than 9.0% of the hospital's patient days are for newborns (see below, "For item 2..."),
- (3) the hospital is located in a county, other than Milwaukee County, that has or is scheduled to have mandatory or optional enrollment in Medicaid managed care in the rate year beginning July 1, and
- (4) for the rate year, the hospital is or becomes a major provider of managed care services to Wisconsin Medicaid Program recipients in the county in which the hospital is located (see below, "For item 4...").

For item 2 above, the ratio of newborn patient days to the hospital's total hospital patient days excluding the newborn patient days must exceed 9.0%. The patient days will be from the hospital's audited cost report used for determining the Medicaid utilization rate for a disproportionate share adjustment under §5243.

For item 4 above, either (1) the hospital must have incurred more inpatient days of service for WMP managed care recipients than any other hospital located in the county during the rate year, or (2) the hospital must have incurred at least 40.0% of the inpatient days of service for WMP managed care recipients provided by hospitals located in the county during the rate year. If neither of these two conditions are met during a rate year, any payments made under this section during the rate year will be recovered from the hospital.

**8420 Payment.**

The supplement will be paid in a prospectively established monthly amount based on the past Medicaid utilization of the qualifying hospitals. The total amount paid in the rate year cannot exceed the amount of the statewide annual maximum for this supplement.

The statewide annual maximum will be allocated to an individual qualifying hospital according to the following formula where:

d	=	Total Medicaid days, including Medicaid HMO days, for an individual qualifying hospital from the calendar year prior to annual rate update.
D	=	Total Medicaid days, including Medicaid HMO days, for all qualifying hospital in the state from the calendar year prior to annual rate update.
M	=	Maximum for the rate year on annual statewide payments under this supplement.
H	=	The portion of the statewide maximum allocated to the individual qualifying hospital for the rate year.
<i>Formula:</i> $(d / D) \times M = H$		

For the individual qualifying hospital, the portion of the statewide maximum allocated to the hospital (H above) for the rate year will be divided by 12 to establish the monthly supplemental payment for the hospital.

**8440 Statewide Maximum**

The total statewide annual maximum for the supplemental payment for each rate year beginning on and after year July 1, 1996 shall be \$250,000.

## SECTION 8500 Pediatric Inpatient Supplement

Supplemental payments are provided to acute care hospitals located in Wisconsin which provide a significant amount of services to persons under age 18. The payments will be subject to the payment limitation of section 9000 by which the total of the overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

### 8510 Qualifying Criteria for Pediatric Inpatient Supplement

A hospital qualifies for this pediatric supplement if the hospital meets the following criteria.

- 1) The hospital is an acute care hospital located in Wisconsin.
- 2) During the hospital's fiscal year described here, inpatient days in the hospital's acute care pediatric units and intensive care pediatric units of the licensed facility totaled more than 12,000 days. Days for stays in neonatal intensive care units are not included in this determination. The inpatient days are counted for the hospital's fiscal year that ended in the second calendar year preceding the beginning of the rate year. For example, for the rate year beginning July 1, 1998, the hospital's fiscal year that ended in 1996 is used.

### 8515 Determination of Supplemental Payment

The pediatric inpatient supplement is paid as a monthly amount established according to the following method. A total of \$2,000,000 is distributed each rate year among hospitals qualifying for this supplement. This is distributed proportionately among qualifying hospitals based on their number of Medicaid pediatric days as described below.

A qualifying hospital's pediatric inpatient supplement will be determined as follows:

$$\begin{aligned}
 \text{Hospital's annual pediatric supplement} &= \frac{\text{Medicaid pediatric days for hospital}}{\text{Sum of Medicaid pediatric days of all qualifying hospitals}} \times \$2,000,000 \text{ Statewide annual funding} \\
 \text{Hospital's monthly pediatric supplement} &= \frac{\text{Hospital's annual pediatric supplement}}{12 \text{ Months}}
 \end{aligned}$$

*Medicaid pediatric days* for the above calculation are a hospital's total covered inpatient days for pediatric Medicaid recipients, including HMO covered pediatric Medicaid recipients, for patient discharges occurring in the rate year that began two years prior to the beginning of the current rate year. (For example, for a current rate year beginning July 1, 1998 the rate year July 1, 1996 through June 30, 1997 is used.) A pediatric patient is a patient that has not attained 18 years of age as of the day of admission. Medicaid pediatric days do not include: (a) days of Medicaid recipient stays that are covered in full or part by Medicare; and (b) days of Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as private hospitalization insurance.

**SECTION 9000**  
**PAYMENT NOT TO EXCEED CHARGES**

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to WMAP recipients. Overall payments from all sources includes, but are not necessarily limited to, WMAP payments, recipient co-payments, third party liability payments, local and related matching FFP amounts under §8000 and the indigent care allowance of §8230. The state fiscal year is July 1 through June 30. Disproportionate share (under sections 5240 and 8250) in the WMAP payment rates will be added to the allowable charges.

If an individual hospital's overall payments for the period exceed charges-plus-disproportionate share, the WMAP will recoup payments in excess of charges-plus-disproportionate share.

## SECTION 9100

### LIMIT ON AMOUNT OF DISPROPORTIONATE SHARE PAYMENT TO A HOSPITAL

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients. The amount of disproportionate share payments which exceed this limit shall be determined retrospectively after a hospital completes its fiscal year.  
(Statutory Background: Section 1923(g) of the federal Social Security Act.)

**Payment Shortfall for MA Recipient Services.** The payment shortfall for MA recipient services is the amount by which the costs of inpatient and outpatient services provided MA recipients exceed the payments made to the hospital for those services excluding disproportionate share hospital payments. Disproportionate share hospital payments are payments provided a hospital under the State of Wisconsin Medicaid State Plan according to the provisions of the Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923. If payments exceed costs, the financial gain from MA payments will be applied against the uncompensated care costs for the uninsured.

The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department. Services provided MA recipients covered by an HMO under the WMAP will be included. For outpatient MA services, interim outpatient payments limited to charges for the hospital's fiscal year will be used. For inpatient MA services, payments limited to charges will be also used. Payments limited to charges will be the lesser of (a) charges made by the hospital during its fiscal year for MA services, or (b) overall payments from all sources (as defined in §9000) for MA services during its fiscal year, excluding disproportionate share payments. This charge limit will be applied separately to payments for inpatient services and payments for outpatient services for the period of the hospital's fiscal year.

**Unrecovered Cost of Uninsured Patients.** The unrecovered cost of uninsured patients is the amount by which the costs of inpatient and outpatient services provided to uninsured patients exceed any cash payments made by them. However, as provided in the Social Security Act, Section 1923(g)(1)(A), "For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government with a State shall not be considered to be a source of third party payment."

If payments exceed costs, the financial gain from payments for the uninsured will be applied against the MA payment shortfall. An uninsured patient is an individual who has no health insurance or source of third party payment for the services provided by the hospital. The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department.

**Recovery of Excess Disproportionate Share Payments.** If total disproportionate share payments to the hospital for services provided during its fiscal year exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients, then the excess disproportionate share payments will be recovered from the hospital.

**Administrative Adjustments.** A hospital may request an administrative adjustment under section 11900, item N, if an amount is to be recovered. The hospital or the Department may initiate an administrative adjustment under item O after completion of the outpatient final settlement for the hospital's fiscal year.

**Effective Date.** This limitation applies only to hospitals owned or operated by a State or by a unit of local government beginning July 1, 1994. With respect to hospitals that are not owned or operated by a State or unit of local government, this limitation applies beginning July 1, 1995 unless the federal Department of Health and Human Services exempts such hospitals or modifies the limitation for them.

For hospitals with fiscal years in progress (not beginning) on July 1, 1994 (or July 1, 1995 if applicable), the MA shortfall and the unrecovered cost of uninsured for the fiscal year will be prorated between the period before July 1 and the period on and after July 1 based on the proportion of disproportionate share payments applicable to each period.

**SECTION 10000**  
**PAYMENT FOR SERVICES PROVIDED IN HOSPITALS OUT-OF-STATE**  
HOSPITALS NOT HAVING BORDER-STATUS AND MINOR BORDER STATUS HOSPITALS

**10100 INTRODUCTION**

Minor border status hospitals and out-of-state hospitals which do not have border status will be paid according to the DRG based payment system described in this section 10000. This payment system provides a single base DRG base rate for all minor border status and non-border status hospitals. This rate is applied to the DRG weights which have been developed for use under section 5000 for in-state hospitals and major border status hospitals. The rates do not consider hospital-specific costs or characteristics as is done for in-state and major border status hospitals. However, a minor border status hospital and a non-border status hospital may request recognition of many of these costs and characteristics through the administrative adjustments described in section 10400.

For any out-of-state hospital, border status or not, certain services will not be reimbursed according to the DRG methodology if the hospital takes the necessary action to receive reimbursement under an available alternative payment. These services and their alternative payment method are described in section 7000 and include AIDS care, ventilator patient care, special unusual cases and brain injury care.

For questions and additional information, out-of-state hospitals may contact the Department at: Division of Health Care Access and Accountability, P.O. Box 309, Madison, Wisconsin 53701-0309; telephone (608) 266-9438

Any pre-established standard payment amounts which are described below and the DRG weighting factors for the current state fiscal year, July 1 through June 30 may be requested from the above address.

**10200 DRG BASED PAYMENT SYSTEM** For Minor Border Status and Non-Border Status Hospitals

**10210 Base DRG Rate**

The base DRG rate for all minor border status and non-border status hospitals shall be the standard DRG group rate which is determined under section 5160 for the hospital grouping entitled "acute care hospitals".

**10211 Wage Area Adjustment Index**

For minor border status hospitals, the base DRG rate will be adjusted by the applicable wage area adjustment index which is described in section 5220. Non-border status hospitals have to take action to request a wage area administrative adjustment, under §10463 if they desire such an adjustment.

**10212 Capital Cost Payment**

An amount shall be added to the base DRG rate for payment of hospital capital costs. The amount shall be 100% of the average capital payment per case-mix-adjusted discharge as determined according to section 5400 for hospital located in Wisconsin. The estimate shall be based on forecasted hospital-specific capital payment rates for in-state for the rate year. A minor border status hospital and a non-border status hospital may request their capital cost payment to be adjusted pursuant to an administrative adjustment under §10464.

### **10230 Cost Outliers**

Minor border status hospitals and non-border status hospital claims may qualify for cost outlier claims under the provisions of section 5320 except for the following modifications.

The cost outlier tripoint for all out-of-state hospital claims will be that tripoint amount per discharge which is provided to general medical/surgical hospitals of 100 or greater beds in Wisconsin. A hospital may request a different tripoint under the administrative adjustments of subsection 10461 and/or subsection 10466.

Outlier payments will be determined with the use of an average state-wide cost-to-charge ratio for WMAP hospital providers located in Wisconsin. The average state-wide cost-to-charge ratio will be the ratio of the total state-wide inpatient hospital costs for WMAP services to the total charges for those services. Costs and charges used will be those used to determine the hospital specific cost-to-charge ratios under section 5322 for each respective rate year.

### **10300 PAYMENT NOT TO EXCEED CHARGES**

For out-of-state hospitals not having border-status, payment on each discharge may not exceed the hospital's charges for allowable services. This limit applies to discharges paid under the DRG based payment system and to payment for services exempt from the DRG payment system. For minor border-status hospitals, payments are limited to charges according to the method described in section 9000. This method limits aggregate annual payments to charges, not by individual claims.

### **10400 ADMINISTRATIVE ADJUSTMENT ACTIONS**

#### **(For Minor Border Status Hospitals and Non-Border Status Hospitals)**

**10410 Introduction.** Administrative adjustment actions provide hospitals with a procedure to have payments for WMAP recipient stays adjusted for many of the hospital-specific adjustments which are routinely provided to hospitals in Wisconsin and to major border status hospitals. Most of the adjustments require the hospital to submit an audited Medicare cost report or other information. The administrative adjustment provisions in section 11000 are not available to minor border status hospitals and non-border status hospitals.

**10415 Reduced Payment Possible.** If an administrative adjustment results in a lesser payment than would have been provided had no administrative adjustment been requested, the lesser amount will be paid by the Department. If an administrative adjustment results in an increased payment, the increase shall be paid by the Department.

**10420 Request Due Date and Adjustment Effective Date.** A hospital must submit a written request to the Department for an administrative adjustment. The request must be delivered within 60 days after the date of a written notice from the Department notifying the hospital of its payment rate in order for the rate to be adjusted retroactively to its original effective date. If the Department had not previously provided written notice to the hospital of the payment rate, the hospital must deliver a written request within 60 days after the date of the WMAP's remittance check to the hospital for payment of a WMAP recipient's stay. If the request is delivered after the 60 day period, then the requested adjustment may be effective on the first of the month following the month in which the request has been delivered. Delivery date is defined in §11610.

The request must specify which of the adjustments described in subsection 10461 through 10469 below are desired. Written requests are to be sent to: Hospitals, Physicians and Clinics Section, Division of Health Care Access and Accountability, P.O. Box 309, Madison, Wisconsin 53701-0309.

**10440 Effective Period.** Administrative adjustments provided by the Department to any out-of-state hospital shall be effective for the rate year for which the adjustment is approved effective. A rate year encompasses the twelve month period July 1 through June 30. The adjustment shall not apply for payment of WMAP recipient discharges in previous or subsequent rate years.

**Effective Period.** For example, a hospital requested a capital payment adjustment under §10464 for a recipient's discharge which occurred on January 23, 1996. The hospital discharges two more WMAP recipients on May 22 and June 3 respectively. The Department will apply the capital payment adjustment to payment of these later discharges. In this example, however, a new rate year will begin on July 1, 1996 and the hospital's capital payment adjustment will lapse. The hospital will need to again request the administrative adjustment for WMAP recipient discharges occurring in the new rate year.

#### **10460 CRITERIA FOR ADMINISTRATIVE ADJUSTMENTS**

For Minor Border Status and Non-border Status Hospitals

##### **10461 Adjustment for being a hospital institution for mental disease (IMD).**

A hospital may request an administrative adjustment to its payment if (1) it is a certified hospital for a state's Title XIX program and (2) is designated as an institution for mental disease (IMD) by the certifying state or by the federal Department of Health and Human Services. The hospital must demonstrate fulfillment of these requirements to the satisfaction of the Department for approval of its request for an adjustment to recognize its IMD status.

Two adjustments may be provided. *First*, the standard DRG group rate, which is provided in section 5160 for "hospital IMDs not in Milwaukee County", may be used as the hospital's base DRG rate in place of the base DRG rate provided in subsection 10210 above. *Second*, the cost outlier trimpoints which is specified in subsection 5320 for hospital IMDs of 100 beds or greater shall be applied to the hospital. (A request can be submitted pursuant to subsection 10466 below for the trimpoint applicable to IMDs under 100 beds.)

##### **10463 Adjustment for an area wage index.**

Payment under the DRG-based payment system may be adjusted by an area wage index, as determined by the Department, upon request by a hospital. The hospital must provide the name of its CMS (Centers for Medicare & Medicaid Services) wage area for the Medicare program. Secondly, the hospital must provide its CMS assigned area wage index which was in effect at the beginning of the state's rate year in which the adjustment is desired to be effective. The state's rate year covers July 1 through June 30.

The Department shall calculate a wage index as follows. The hospital's CMS wage index will be divided by the CMS wage index for hospitals in, not reclassified to, the Madison, Wisconsin wage area. The quotient will be multiplied by the WMAP wage index for original remaining hospitals in the Madison area. The result is the wage adjustment index for the hospital. The WMAP's area wage index for Madison is listed in appendix section 27000.

The base DRG rate shall be adjusted as follows. The base DRG rate shall be reduced by that portion related to capital costs. The remaining amount will be multiplied by the wage differential factor of .7495 and that result will be multiplied by the wage adjustment index determined above for the hospital. The resulting amount plus the capital cost portion is the hospital's adjusted base DRG rate.

##### **10464 Adjustment of capital cost payment**

A hospital may request an adjustment to its capital cost payment. The hospital must submit a copy of its audited Medicare cost report for its most recent fiscal period for which an audit has been completed. The Department will calculate the hospital's capital cost ratio from information in the audited cost report. The hospital's capital cost ratio shall be total allowable capital costs divided by total allowable costs excluding capital costs and direct medical education costs.

The hospital's capital cost ratio shall be multiplied by the standard DRG group rate under section 5160 for "general medical and surgical hospitals not in Milwaukee County". The resulting product is the adjusted capital cost payment for the hospital. This adjusted amount shall be used to establish the hospital's base DRG rate in lieu of the capital cost payment provided under subsection 10212.



**10465 Disproportionate share adjustment applied to payments.**

A hospital may request a disproportionate share adjustment to its payment if it qualifies under the provisions of section 5240. The amount of the adjustment will be determined as is provided in section 5240. The hospital will have to submit verifiable patient day data for determination of the adjustment.

**10466 Adjustment of cost outlier tripoint for hospitals under 100 beds**

If a hospital's bed capacity is under 100 beds, then the hospital may request its cost outlier tripoint to be set at the tripoint per discharge which is provided to hospitals located in Wisconsin under section 5320. The hospital must submit evidence to the satisfaction of the Department that its bed capacity is less than 100 beds and that the hospital is not an IMD.

**10467 Facility-specific cost-to-charge ratio for use in outlier payment calculation**

A hospital may request use of its facility-specific cost-to-charge ratio for use in the calculation of outlier claim payments. The hospital must submit a copy of its audited Medicare cost report for its most recent fiscal period for which an audit has been completed. The Department will calculate the hospital's overall cost-to-charges ratio from information in the audited cost report. If the hospital has no audited cost report, then the hospital must submit a copy of its most recently completed unaudited cost report. The Department has the option to not accept the unaudited cost report and to withhold any administrative adjustment action until an audited cost report is available.

**10468 Correcting adjustment due to inappropriate calculation of adjustments, including clerical errors, and changes resulting from the reopening of an audited Medicare cost report.**

An inappropriate calculation of an adjustment is the application of the administrative adjustment criteria to incomplete or incorrect data contained in a cost report or to other data used by the Department to determine an administrative adjustment. Data or information supplied by the hospital to support a correcting adjustment must be auditable and to the satisfaction of the Department.

If the hospital's request for a correcting adjustment is the result of a reopened Medicare cost report, the Department shall allow the correcting adjustment if the request is received by the Department within five (5) years from the end of the reopened cost reporting period and if the dollar effect of the correcting adjustment on WMAP payments to the out-of-state hospital is \$5,000 or greater.

**10469 Per Diem Rate for Out-of-State Rehabilitation Hospitals**

A minor border status hospital or a non-border status hospital which qualifies as a rehabilitation hospital may request to be exempted from DRG based payment and paid under a rate per diem. The rate per diem to be paid shall be an average of the rates being paid to other rehabilitation hospitals located in Wisconsin at the time of the MA recipient's admission, not including rates being paid new rehabilitation hospitals during a start-up period. If a rate being paid to a rehabilitation hospital is adjusted as is called for in step 1 of §6310, the statewide average rate will not be recalculated and adjusted for the out-of-state hospital until the July 1 subsequent to the patient's admission. (Payment rates are customarily adjusted each July 1 for all hospitals.) A rehabilitation hospital is a hospital that provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures and multiple trauma to at least 75% of its patient population.

**10600 PAYMENT FOR OUT-OF-STATE HOSPITAL SERVICES, STANDARDIZED AMOUNTS**

For Rate Year July 1, 1997 Through June 30, 1998

A schedule of the current standardized payments is available from the WMAP at the following address or telephone numbers.

Division of Health Care  
Access and Accountability  
P. O. Box 309  
Madison, WI 53701-0309

Telephone (608) 267-9589  
FAX Telephone (608) 266-1096  
Voice/TDD 1-800-362-3002

SUBSECTION REFERENCE	TOPIC	AMOUNT
For a current listing of DRG weighting factors, contact the WMAP at the above address or telephone.		
<b>10210</b> Base DRG Rate	Base DRG rate including an amount for capital cost payment per discharge	Contact WMAP
<b>10220</b> Psychiatric Stays	DRG weights for psychiatric stays in four mutually exclusive hospital groups	Contact WMAP
<b>10230</b> Cost Outliers	Base cost outlier tripoint per discharge	\$ 31,410 per discharge
	Cost-to-charge ratio	Contact WMAP
<b>10461</b> Hospital IMD	Base DRG rate for hospital IMDs not in Milwaukee County (including capital cost payment per discharge).	Contact WMAP
	DRG weighting factors for psychiatric stays for group "all other IMD hospitals, not located in Milwaukee County.	Contact WMAP
	Cost outlier tripoints per discharge for IMDs (See 10466 for available adjustment if IMD is under 100 beds)	\$ 31,633 per discharge
<b>10462</b> Psychiatric DRG weights for hospital with Medicare-exempt psychiatric unit	DRG weighting factors for psychiatric stays for hospital grouping entitled "all other IMD hospitals, not located in Milwaukee county"	Contact WMAP
<b>10463</b> Area wage index	WMAP wage index for original remaining hospitals in the Madison wage area	Contact WMAP
<b>10466</b> Cost outlier tripoint for hospitals under 100 beds	For general medical/surgical hospitals under 100 beds	\$ 5,235 per discharge
	For hospital IMDs under 100 beds (determined IMD per subsection 10461)	\$ 5,460 per discharge

**SECTION 11000**  
**ADMINISTRATIVE ADJUSTMENT ACTIONS**  
**For Hospitals In Wisconsin and Major Border Status Hospitals**

**11010 Introduction.** The Department provides an administrative adjustment procedure that allows individual hospitals an opportunity to receive prompt administrative review of payment rates for those special circumstances and occurrences which meet the criteria described in §11900 below. It is up to a hospital to request an administrative adjustment or the Department to initiate an administrative adjustment.

Department staff review a request for an adjustment and determine if it should be denied or approved and, if approved, the amount of adjustment. If the hospital disputes the staff determination, the administrative adjustment request can be forwarded for review to the Administrative Adjustment Committee (AAC). The AAC provides a recommendation to the Department regarding the disputed adjustment. A detailed description of the policies and procedures for processing administrative adjustments is in Appendix §28000.

A hospital may file a Chapter 227 appeal regarding the Department's final decision. The appeal would be filed in accordance with the requirements of Chapter 227, Wis. Stats.

The payment rate for a hospital covered by the DRG based payment system is a schedule of several distinct components which, when applied, result in a total payment for services provided by a hospital to MA recipients. An administrative adjustment may involve the adjusting of one or more of these components.

The per diem rate for hospitals paid under a per diem rate at \$6000 may have that rate adjusted through administrative adjustment actions described §11900 below. Administrative adjustment actions are not applicable to AIDS rates at §7100 and ventilator-assistance rates at §7200.

This §11000 applies only to in-state hospitals and major border status hospitals. Administrative adjustment actions for minor border status hospitals and non-border status hospitals are described in §10400.

**11100 Hospital's Submission of Request for Adjustment.**

A hospital must deliver a sufficient written request to the Department for an administrative adjustment. In order to be considered sufficient, the following items must be clearly identifiable in the written request: (1) that the request applies to its inpatient rate, (2) the effective date of the rate for which an adjustment is being requested, and (3) the specific administrative adjustment, circumstances or occurrences described in §11900 for which the hospital is making its request for an adjustment. The Department may, at its discretion, pursue clarification of an incomplete request and ask the hospital to submit a sufficient request.

A hospital needs to deliver a separate administrative adjustment request for each rate year. A rate year encompasses the twelve month period July 1 through June 30.

For example, in rate year Y1, a hospital requested and received an administrative adjustment to its capital cost reimbursement for a major building program pursuant to §11900-C. If the hospital wants the same administrative adjustment in rate year Y2, then the hospital must submit a new request when the Y2 rate year arrives. The request for rate year Y1 does not carry-over to rate year Y2. For rate year Y3, the hospital would again have to request the adjustment when it comes to rate year Y3.

Requests should be addressed to:

Division of Health Care Access and Accountability  
1 W. Wilson Street, Room 350  
P. O. Box 309  
Madison, Wisconsin 53701-0309.

The FAX telephone number is (608) 266-1096 but may change without notice.

#### **11120 Due Date of Request and Effective Date of Adjustment.**

The due date of a sufficient request and the effective date of any adjustment is described under each of the administrative adjustments listed in §11900.

For most but not all administrative adjustments, the "60 day rule" described in §11600 below will apply. To summarize the 60 day rule, if a request is delivered to the Department with 60 days of a rate notice from the Department, then the adjustment can be effective retroactively. If delivered after 60 days, the adjustment may be effective prospectively.

#### **11150 Initiation of Adjustment by Department.**

The Department may initiate an administrative adjustment. The Department will notify the hospital in writing that it has initiated an administrative adjustment. The effective date of the adjustment will be established according to "the 60 day rule" described in §11600 below.

#### **11200 Reduced Payment Possible.**

If an administrative adjustment results in a lesser payment than would have been provided had no administrative adjustment been applied, the lesser amount will be paid. If an administrative adjustment results in an increased payment, the increase shall be paid.

#### **11300 Withdrawal.**

Once Department staff has calculated the adjustment requested by a hospital and notified the hospital of the results, whether an interim or final adjustment, the hospital cannot withdraw its request for the administrative adjustment. The Department cannot withdraw an administrative adjustment it initiated after it has notified the hospital according to §11150.

#### **11500 Effective Period of an Administrative Adjustment.**

The effective period of any adjustment is described under each of the administrative adjustments listed in §11900. Most but not necessarily all administrative adjustments will be effective through the end of the rate year in which the administratively adjusted payment rate is effective and will expire at the end of that rate year. A rate year encompasses the twelve month period July 1 through June 30.

For example, a hospital was notified of its July 1, 1993 rate in a notification from the Department dated July 7, 1993. On August 16, 1993, the hospital delivered a request for an administrative adjustment to its rate. According to the 60 day rule, the Department may approve the adjustment retroactively effective to July 1, 1993. The adjustment will expire after June 30, 1994. For its new rate effective July 1, 1994, the hospital must submit a new administrative adjustment request.

The Department may modify the amount of the administrative adjustment when the criteria below calls for such a modification or when the Department finds that there was an inappropriate calculation of the payment rate and/or an adjustment to the payment rate.

#### **11600 The 60 Day Rule.**

The effective date of an administratively adjusted payment rate shall depend on when the hospital requests the adjustment or the Department initiates the adjustment. For most but not all administrative adjustments, the effective date shall be established according to the following subsections.

**11610 Definition, "Delivery date".**

The U.S. Postal Service postmark date will be considered delivery date of a mailed administrative adjustment request. If delivered by FAX machine, the inscripted date from the Department's FAX machine shall be considered delivery date. Delivery date under any method, other than U.S. mail or FAX, shall be the day the Department receives delivery.

The Department is not responsible for written requests which are lost in transit to the Department. If lost, the hospital must demonstrate to the satisfaction of the Department that a "delivery date" had been established according to the above criteria. The Department recommends that hospitals use registered return-receipt U.S. mail in order that they have documentation of the postmark date and that the Department received the request.

**11620 Definition, "Final rate notification".**

A final rate notification, or a final notification of the rate, is a written notice to a hospital from the Department which lists one or more changed components of the hospital's rate schedule and which includes notice that the hospital has 60 days to request an administrative adjustment.

**11630 Requested by Hospital Within 60 Days After Rate Notification.**

A hospital must deliver a written request for an administrative adjustment *within the 60 day period* after the date of a final rate notification from the Department in order for the requested adjustment to take effect *on the original effective date* of the rates being adjusted. (See example in §11500.) The Department's notice of the adjusted rate does not start a new 60 day period.

**11640 Requested by Hospital After 60 Days From Rate Notification.**

If a hospital delivers a written request to the Department for an administrative adjustment *more than 60 days* after the date of a final rate notification from the Department, then any adjusted rate which results from the administrative adjustment request shall take effect on the *first of the month following the delivery date*. The Department's notice of the adjusted rate does not start a new 60 day period.

If "the first of the month following the delivery date" is in a new rate year, the request will be denied. This means that an administrative adjustment request with a delivery date after May 31 of the rate year will be denied.

For example, August 3, 1993 was the date of a hospital's final rate notification for its rate effective July 1, 1993. On June 3, 1994 the hospital delivered a request for an administrative adjustment to its July 1, 1993 rate. According to the above 60 day rule, the adjustment would be effective July 1, 1994 which is the first of the month following the delivery date of the request. However, the request will be denied because July 1, 1994 is the beginning of a new rate year. It should be noted that the hospital may resubmit the administrative adjustment request specifically for its new July 1, 1994 rate.

**11650 Requested by Hospital Before New Rate Year Begins.**

A hospital may wish to request an administrative adjustment before a new rate year begins. Such requests will only be accepted if delivered to the Department *on or after the May 1* date preceding the beginning of the new rate year. A new rate year begins every July 1. When a hospital receives its new rate notification from the Department, it should verify that the new rate includes the requested adjustment.

**11660 Administrative Adjustments Initiated by the Department.**

If the Department initiates the adjustment within 60 days after the date of a final rate notification, the adjustment shall take effect on the original effective date of the rates being adjusted. If the Department initiates the adjustment more than 60 days after the date of a final rate notification, the adjustment shall take effect on the first of the month following the date on which the Department initiates the adjustment. The date the Department initiates the adjustment is the date of the written notification which is provided to the hospital according to §11150. A new 60 day rule period shall be allowed the hospital commencing with the date of notification to the hospital of the adjusted rate if the Department's adjustment causes a reduction of reimbursement.

The Department may initiate an administrative adjustment when it establishes a hospital's rate for a new rate year and include the adjustment in the Department's rate notification to the hospital.

**11670 Correction of Inappropriate Calculations.**

The Department may find an inappropriate calculation of a hospital's rate coincident with its processing a hospital's administrative adjustment, whether requested by the hospital or initiated by the Department. An inappropriate calculation of rates is defined in §11900-A. The Department's correction of the inappropriate calculation will be effective the date the administrative adjustment is effective. If a requested adjustment is denied, the correction of the inappropriate calculation found by the Department will be effective the date the requested adjustment would have been effective had it been approved. A new 60 day rule period shall be allowed the hospital commencing with the date of notification to the hospital of the corrected rate if the correction causes a reduction of reimbursement.

For example, the adjustment requested by a hospital provided a \$10 rate increase. An inappropriate calculation found by the Department caused a \$2 decrease. Even though the net effect is an \$8 rate increase, the isolated effect of the Department's correction caused a \$2 decrease. As a result, the hospital will have a new 60 day period for requesting an administrative adjustment.

## 11900 CRITERIA FOR ADMINISTRATIVE ADJUSTMENT ACTIONS

For In-State Hospitals and Major Border Status Hospitals

Requests for an administrative adjustment may be submitted by hospitals for one or more of the following specific circumstances or occurrences.

### A. Correction of Inappropriate Calculation of Rates

*Qualifying Determination:* One or more components of the payment rate schedule must have been inappropriately calculated under the rate setting plan. An inappropriate calculation is:

- (1) The application of the rate setting methodology or standards to incomplete or incorrect data contained in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or
- (2) A clerical error in calculating a component of the hospital's payment rate schedule, or
- (3) Incorrect or incomplete application by the Department of provisions of the rate setting methodology or standards in determining one or more components of the hospital's payment rate schedule or in determining any administrative adjustment of a hospital's payment rate schedule.

(Note that the rate setting methodology and standards are specified in attachment 4.19A of the State Plan.)

*Request Due Date and Effective Date:* The 60 day rule applies per §11600 above. For rate calculation corrections initiated by the Department, the 60 day rule does not apply if data is corrected which has not been audited by the Department or by an agent of the Department for the Wisconsin Medical Assistance Program. Any resulting corrected rates may be retroactively effective to the original effective date of the rate being corrected.

*Expiration of Adjustment:* The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

*Adjustment Procedure:* The hospital must supply data or information to the Department to support an adjustment. The data must be able to be audited currently or at a later time by the Department. An audited cost report of the hospital may need to be reopened in order to resolve the adjustment request.

*Reopening Audited Cost Report:* Either the hospital or the Department may request that the Medicaid audit contractor reopen an audited cost report. An audited cost report may be reopened only if all of the following conditions are satisfied: (1) the dollar effect is \$5,000 or greater, (2) the statistic affecting the payment rate is in error by 5% or more, and (3) the request for reopening and the necessary data is submitted to the audit contractor within five years from the end date of the cost reporting period for which the cost report is being reopened. The audit contractor will apply these conditions.

The Department may request that the audit contractor obtain additional data or perform additional audit tests when reopening a cost report. The audit contractor's charge to the Department for reopening a cost report may be billed to the provider if it was the provider's error that was in need of correction.

*Legal Review Pursued by Hospital:* Corrections of payment rate calculations must be pursued by a hospital through this administrative adjustment before the hospital can pursue legal review of its rate calculation. If a hospital does pursue any available legal review after requesting an administrative adjustment, the Department will withdraw any proposed rate adjustment as to any given issue it has offered to the hospital, and the Department will not put the adjusted payment rate into effect. If the adjusted payment has been put into effect and is an increase over the payment previously in effect, the adjusted payment will be retroactively rescinded to the date it was effective and replaced with the payment in effect prior to the adjustment. In such a case, increased payments at the adjusted rate will be recovered by the Department.

**B. Use More Current Cost Report If Available Cost Report Is More Than Three Years Old**

A hospital's audited cost report which is on file with the Department is the basis for determining: (1) the disproportionate share adjustment under §5243, (2) capital payment under §5400, (3) direct medical education payment under §5500, (4) the cost to charge ratio for outlier payments under §5300, and (5), for hospitals in Wisconsin, the rural hospital adjustment under §5260.

If any of the payment components are based on an audited cost report period which is more than three years old, this administrative adjustment allows an adjustment of all of the above payment factors based on a more current audited cost reporting period. All factors requiring cost report data will be adjusted with no option by the hospital or the Department to elect to adjust only some of the payment factors. The reimbursement a hospital receives may increase or decrease as a result of using the more current cost report data.

**Qualifying Determination:** The end date of the period of the audited cost report used by the Department for establishing any component of a hospital's specific payment rate precedes the effective date of the payment rate by more than three years and three months.

For example, for a hospital's payment rates effective July 1, 1994, the Department used the hospital's audited cost report for its fiscal year ended December 31, 1990. Back-up 3 months from July 1, 1994 to April 1, 1994 and then subtract 3 years from 1994 resulting in a date of April 1, 1991. The hospital would qualify because its cost report used for establishing payment rates ended before April 1, 1991.

**Request Due Date and Effective Date:** The 60 day rule applies per §11600 above.

**Expiration of Adjustment:** The adjustment expires at the end of the rate year in which the administratively adjusted payments are effective. A rate year ends each June 30th. (See §11500 above for more detail.)

**Definition, Updating Fiscal Year:** The *updating fiscal year* is the first fiscal year of the hospital which ended on or after date three years and three months prior to the effective date of the payment rates.

For example, a hospital has a fiscal year ending September 30. The hospital's rate effective July 1, 1994 was based on its September 30, 1990 fiscal year cost report. Its updating fiscal year would be its fiscal year, which ended September 30, 1991. (The reference date was calculated by backing-up 3 months from July 1, 1994, to April 1, 1994 and then subtracting 3 years from 1994.)

**Interim Adjustment:** The audited cost report for the updating fiscal year may not be available at the time a hospital requests this administrative adjustment. The Department may provide interim adjusted payment amounts until the cost report is available. Upon consultation with the Department, the hospital must provide the Department sufficient information in order that the interim adjustment is a reasonable and reliable estimate of the final expected capital and direct medical education payment rates, the disproportionate share adjustment, the outlier cost to charge ratio, and the rural adjustment.

**Final Adjustment:** After the Department receives an audited Medicaid cost report for the updating fiscal year, all four payment factors will be calculated and adjusted based on the audited data, specifically: (1) the disproportionate share adjustment, (2) the capital payment, (3) the direct medical education payment, (4) the hospital's cost to charge ratio for outlier payments, and (5) the rural adjustment. The payment amounts will be determined according to the rate setting methodology that was in effect for the period for which the final adjusted payment amounts are to be effective. A recoupment or payout will be made for the period for which the final adjusted payment factors apply.

**Adjustment for Inflation:** A table of the inflation rate multipliers which are to be used for interim and final adjustments of capital and direct medical education payments effective in a specific rate year are listed in Appendix 27200.



## **C Capital Payment Adjustment for Major Capitalized Expenditures, Effective January 1, 1996**

This administrative adjustment provides for an updating of a hospital's capital payment. It provides a means through which a hospital can have its capital payment adjusted to recognize recent major expenditures that improve, add to, or replace existing equipment and structures that are directly or indirectly used for inpatient services. The following criteria apply to capital payment rates in effect for inpatient services with dates of discharge on and after January 1, 1996.

**Qualifying Determination:** A hospital qualifies for this adjustment if the hospital's total capitalized depreciable assets at the *end* of the hospital's updating fiscal year have increased by an amount that is 25% or greater of total capitalized depreciable assets at the *beginning* of the base cost report period. Qualification will be determined by comparing the amount of capitalized depreciable assets reported in the hospital's audited financial statements for the respective comparison dates. If audited financial statements are not available to determine qualification, the hospital can request this adjustment and an interim adjustment will be provided pending completion of audited financial statements. Interim adjustments are described below.

**Request Due Date and Effective Date:** The 60-day rule applies per §11600 above. However, requests delivered by June 30, 1996 may be effective January 1, 1996 at the request of the hospital.

**Expiration of Adjustment:** The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30. (Reference: §11500)

### **Definitions**

**Rate year.** A *rate year* is the twelve months July 1 through June 30 (also defined in §3000)

**Capitalized depreciable assets.** *Capitalized depreciable assets* include depreciable land improvements, buildings, fixed equipment and moveable equipment owned by the hospital and such assets leased by the hospital through capitalized leases and excludes capitalized construction-in-progress.

**Base fiscal year cost report.** The *base fiscal year cost report* is the audited Medicaid cost report used to calculate the capital payment for which an administrative adjustment is requested. If this adjustment is requested and the hospital also requests a capital payment adjustment due to the use of a cost report being more than three years old (adjustment B), then the updating cost report, which is used for the old cost report adjustment, will be the base cost report for this adjustment.

**Audited financial statements.** The *audited financial statements* of the hospital are its independently audited financial statements with a statement of audit scope and opinion by a certified public accountant.

**Updating fiscal year cost report.** For adjustments effective on and after January 1, 1996, the *updating fiscal year cost report* is the Medicaid cost report for the fiscal year that ended in the rate year in which the payment adjustment is effective. For example, a hospital's fiscal year ends December 31. The hospital requested a capital adjustment effective July 1, 1996. The updating cost report for that capital adjustment will be its cost report for its fiscal year ending December 31, 1996. For the next year the hospital requested and received a capital adjustment July 1, 1997 for the same capital project. For that adjustment, the updating cost report will be from its fiscal year ending December 31, 1997.

**Interim Adjustment:** The Department may provide an interim adjusted capital payment rate until a final adjustment can be calculated. Upon consultation with the Department, the hospital must provide the Department sufficient information so that the interim adjustment is a reasonable and reliable estimate of the final expected capital payment rate.

**Final Adjustment:** After the Department receives an audited Medicaid cost report for the updating fiscal year, a retroactive adjustment will be calculated based on the audited data and a recoupment or payout will be made for the period for which the interim capital payment was made. The final adjusted rates will be determined according to §5400 of the rate setting methodology in effect for the period for which the final adjusted payment is to be effective. A table of the inflation rate multipliers, which are to be used for final adjustments effective in a specific rate year, are listed in Appendix 27200.

**Special Provision for Adjustment Effective July to December 1995:** Any hospital that requested and received an adjustment effective in July through December 1995 will have two final settlements calculated for the rate year July 1995 through June 1996. One final adjustment will be calculated according to item C.2 for July through December 1995 and a second final adjustment will be calculated according to this item C.1 for January through June 1996.

**D Adjustment for Changes in Medical Education, Effective July 1, 2003, hospitals not located in Wisconsin may not receive an administrative adjustment under this section.**

This administrative adjustment provides for an updating of a hospital's medical education payment for its medical education program. It provides a means through which a hospital's starting, significantly altering or ending a medical education program may be recognized. The following criteria apply to medical education payment rates in effect for inpatient services with dates of discharge on and after January 1, 1996. That is, the direct medical education payment will be adjusted.

*Qualifying Determination:* A hospital's rate of payment for its direct expense of a medical education program may be adjusted in a rate year upon a significant change in its direct medical education expenses. To determine if a change is significant for a hospital: (1) its total direct medical education expenses from the updating fiscal year will be inflated to the rate year in which the adjustment is effective, (2) its total direct medical education expenses from its base fiscal year will be inflated to the rate year in which the adjustment is effective, and (3) the difference, item 1 minus item 2, divided by the inflated base year amount, item 2, must be at least 10% to qualify as a significant change for this adjustment. A table of the inflation rate multipliers that are to be used for adjustments effective in a specific rate year are listed in Appendix 27200. If a cost report does not cover a year, the expense will be annualized.

*Request Due Date and Effective Date:* The 60-day rule applies per §11600 above. However, requests delivered by June 30, 1996 may be effective January 1, 1996 at the hospital's request.

*Expiration of Adjustment:* The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30. (Reference §11500.)

**Definitions**

*Rate year.* A rate year is the twelve months July 1 through June 30 (also defined in §3000)

*Base fiscal year cost report.* The base fiscal year cost report is the Medicaid cost report used to calculate the direct medical education payment for which an administrative adjustment is requested. If this adjustment is requested and the hospital also requests an adjustment due to the use of a cost report being more than three years old (adjustment B), then the updating cost report, which is used for the old cost report adjustment, will be the base cost report for this adjustment.

*Updating fiscal year cost report.* For adjustments effective on and after January 1, 1996, the updating fiscal year cost report is the Medicaid cost report for the fiscal year that ended in the rate year in which the adjustment is effective. For example, a hospital's fiscal year ends December 31. The hospital requested an adjustment effective July 1, 1996. The updating cost report for the final adjustment (described below) will be its cost report for its December 31, 1996 ending fiscal year.

*Interim Adjustment:* The Department may provide an interim adjusted medical education payment until a final adjustment can be calculated. Upon consultation with the Department, the hospital must provide the Department sufficient information so that the interim adjustment is a reasonable and reliable estimate of the final expected medical education payment.

The information provided by the hospital to the Department may not sufficiently show that the hospital does or will qualify for an adjustment. Under such a circumstance, the Department will determine qualification and an interim payment when sufficient data is available or when the final adjustment can be completed, whichever comes first.

*Final Adjustment:* After the Department receives an audited Medicaid cost report for the updating fiscal year, a retroactive adjustment will be calculated based on the audited data and a recoupment or payout will be made for the period for which the interim payment adjustments were provided for direct medical education expenses. The adjusted final rate of payment will be allowed or denied by application of the above qualification standard. If allowed, the final adjusted rates will be determined according to the rate setting methodology in effect for the period for which the final adjusted payments are to be effective. The direct medical education payment rate will be determined according to §5500. A table of the inflation rate multipliers, which are to be used for final adjustments effective in a specific rate year, are listed in Appendix 27200. Recoupment from or payments to the hospital will be made to reconcile actual payments to the final adjusted rate for the period for which the final rate of payment applies.

*Special Provision for Adjustment Effective July to December 1995:* Any hospital that requested and received an adjustment effective in July through December 1995 will have two final settlements calculated for the rate year July 1995 through June 1996. One final adjustment will be calculated according to item C.2 for July through December 1995 and a second final adjustment will be calculated according to this item C.1 for January through June 1996.

**F. Reclassification of Hospital to Different Wage Area**

Requests for this adjustment are due by the April 30th date before the July 1 annual rate update.

The standard DRG group rate which is applicable to a hospital is adjusted by a wage area index pursuant to §5220. Wage areas are identified by the metropolitan statistical areas (MSAs) and the rural areas which are used by CMS in the Medicare program.

*Qualifying Determination:* If the Medicare Geographic Classification Review Board (MGCRB) has reclassified a hospital to a wage area, other than the area of its physical location, the hospital may, through this administrative adjustment, request the Department to recognize the reclassification for determining Wisconsin Medicaid rates. The hospital will have to submit documentation of the MGCRB reclassification decision to the Department.

A reclassification by the MGCRB which is effective for a federal fiscal year beginning on October 1 will be recognized by the Department for the Wisconsin Medicaid rate year beginning the preceding July 1.

The Department has divided the Medicare Milwaukee MSA into two wage areas, (1) a Milwaukee county only wage area, and (2) an Ozaukee-Washington-Waukesha counties' wage areas. The Department will not place any hospital, which was reclassified by Medicare to the Milwaukee MSA, into the Department's Milwaukee county only wage area. Such a hospital will be placed in the Department's Ozaukee-Washington-Waukesha county wage area.

*Request Due Date and Effective Date:* In order for a reclassification to be recognized in a specific rate year beginning July 1, a hospital must deliver its request for reclassification by April 30 prior to the beginning of that rate year. The Department may extend this due date if the hospital does not receive notice of a reclassification decision from the MGCRB before the April 15 date prior to the April 30 due date.

A hospital may withdraw a request for reclassification, which it had previously submitted, by delivering a written notice of its withdrawal to the Department by April 30 without regard as to whether or not the hospital has or will withdraw its reclassification in the Medicare program.

*Expiration of Adjustment:* The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. A hospital's wage area reclassification will be granted for only one rate year. A new request must be submitted for any subsequent rate year. (Reference §11500 above.)

For example, on March 26, 1993, a hospital received a notice from the MGCRB that it was reclassified for the federal fiscal year October 1, 1993 through September 30, 1994. The hospital must submit its request for a reclassification to the Department by April 30, 1993 in order for the reclassification to be recognized in the hospital's Medicaid rates effective July 1, 1993 through June 30, 1994. If in 1994 the hospital is again reclassified by the MGCRB, then it must submit a new reclassification request to the Department for its July 1994 through June 1995 Medicaid rates.

*Adjustment Procedure:* A hospital's wage area reclassification will be recognized in the calculation of wage area adjustment indices according to the method described in §5220.

## **I. Adjustment for PEI Ceasing to be Mandatory**

Section 5160 provides that if the HMO/PEI ceases to be mandatory in Milwaukee County, the Department will eliminate the Milwaukee county-wide adverse selection adjustment from hospital-specific DRG base rates.

*Qualification Determination:* If the HMO Preferred Enrollment Initiative (PEI) ceases to be mandatory in Milwaukee county, a hospital located in Milwaukee county may request continuation of an adverse selection adjustment to consider the remaining volume of voluntary PEI discharges.

*Request Due Date and Effective Date:* The 60 day rule per §11600 applies when a hospital is notified of its hospital-specific DRG base rate which is adjusted to eliminate the Milwaukee county-wide adverse selection adjustment.

*Expiration of Adjustment:* The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. The hospital has to request this adjustment each rate year thereafter. (Reference §11500 above.)

*Adjustment Procedure:* The hospital will be eligible for an HMO adverse selection adjustment percentage in proportion to the remaining volume of PEI discharges but not exceeding the adverse selection adjustment percentage provided in §5160. The adjustment would be calculated by multiplying the adverse selection adjustment percentage provided in §5160 by the voluntary/mandatory ratio. The voluntary/mandatory ratio is the ratio of the number of PEI inpatient discharges in the first twelve months after the PEI went voluntary to the PEI inpatient discharges in the last twelve months before the initiative went voluntary. This adjustment will be calculated after auditable logs of PEI admissions are submitted to the Department for both twelve month periods.

Following is an example of the calculation. Hospital A had 1000 HMO/PEI discharges in the last year of the mandatory PEI program, and 100 HMO/PEI discharges in the first year the program went voluntary. The adverse selection adjustment percentage in §5160 is 10%.

*Calculation:*        1)        100 PEI cases divided by 1000 PEI cases = .1  
                             2)        .1 X 10% = .01 or 1%

Hospital A would receive a 1% HMO adverse selection adjustment.

## **J. Administrative Adjustment for Professional Component, Not applicable after December 31, 1991.**

## **K. Eligibility for Rural Hospital Adjustment Considering Days Provided Under Out-of-State Medicaid Programs and/or Governmental Programs Other Than Medicare and Medicaid**

*Qualifying Determination:* This administrative adjustment allows the inclusion of out-of-state Medicaid days and days associated with other government programs in determining eligibility for the rural hospital adjustment of §5260. A hospital may request this administrative adjustment if it would qualify for the rural hospital adjustment according to the criteria provided in §5260.1 but does not qualify solely because its combined Medicare and Medicaid utilization is less than 55%.

*Request Due Date and Effective Date:* The 60 day rule per §11600 above applies.

*Continuation -- Other Government Programs Considered in Rural Adjustment*

**Expiration of Adjustment:** The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

**Adjustment Procedure:** The inpatient days associated with hospital stays of (1) enrollees in Medicaid programs of states other than Wisconsin and (2) enrollees in other public assistance governmental health programs will be recognized in determining eligibility for the rural hospital adjustment of §5260. These inpatient days will be included in the numerator of the utilization rate, with Medicare and Medicaid inpatient days, for determining eligibility. If the resulting utilization rate equals or exceeds 55%, the hospital is eligible for a rural hospital adjustment. Data submitted by the hospital may be audited at a later date and, if the data is found to be in error, the Department will recover any overpayment that resulted from the erroneous data.

**L. Adjustment to Rural Hospital Adjustment Percentage  
for Substantial Increase in Medicaid Utilization.**

**Qualifying Determination:** A hospital may request this administrative adjustment if it qualifies for the rural hospital adjustment according to §5260.1 and had a current Medicaid utilization which is at least 25% greater than the Medicaid utilization on which the hospital's rural adjustment was determined.

**Request Due Date and Effective Date:** The 60 day rule per §11600 above applies.

**Expiration of Adjustment:** The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

**Adjustment Procedure:** The hospital will need to furnish Medicaid inpatient days and total inpatient days from a current twelve month period which is acceptable to the Department. The inpatient days should exclude long-term care days from hospital swing-beds. The inpatient days may include the inpatient days of enrollees in Medicaid programs of states other than Wisconsin. The rural hospital adjustment percentage will be determined according to §5260.1 based on this new data. The data may be audited at a later date and, if the data is found to be in error, the Department will recover any overpayment that results from the erroneous data.

**M. Adjustment to Rural Hospital Adjustment Percentage  
for Recognition of Out-of-State Medicaid Days**

**Qualifying Determination:** A rural hospital may request this administrative adjustment to recognize inpatient days of enrollees of Medicaid programs other than the Wisconsin Medical Assistance Program (out-of-state Medicaid). A hospital may request this administrative adjustment if it qualifies for the rural hospital adjustment according to §5260.1.

**Request Due Date and Effective Date:** The 60 day rule per §11600 above applies.

**Expiration of Adjustment:** The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

**Adjustment Procedure:** The hospital will need to furnish out-of-state Medicaid inpatient days for the same reporting period of the Wisconsin Medicaid days which were used in establishing the rural hospital adjustment percentage. The rural hospital adjustment percentage will be determined based on a Medicare and Medicaid utilization rate which includes out-of-state Medicaid days. The data may be audited at a later date and, if the data is found to be in error, the Department will recover any overpayment that result from the erroneous data.

**N. Recalculation of DSH Cost Limitation of §9100 With Additional Information**

*Qualifying Determination:* If the Department determines that all or a portion of the disproportionate share (DSH) payments made to a hospital during its fiscal year are to be recovered under §9100, then the hospital may request a recalculation of the recovery amount based on alternative or additional information.

*Request Due Date:* The request for this administrative adjustment must be delivered to the Department within a due date specified in a letter from the Department to the hospital in which it is notified of the amount to be recovered.

*Adjustment Procedure:* The Department will recalculate the disproportionate share payment limitation under §5248 after the hospital has provided alternative or additional information acceptable to the Department for use in the recalculation. The Department may require the information to be provided within a limited period.

**O. Recalculation of DSH Cost Limitation of §5248 Upon Settlement of Outpatient Reimbursement.**

*Qualifying Determination:* The hospital or the Department may initiate a recalculation of the disproportionate share (DSH) limitation of §5248 for the hospital's fiscal year at the time of settlement of outpatient reimbursement for the fiscal year.

*Request Due Date:* The hospital's request for this administrative adjustment must be delivered to the Department within a due date specified in a letter from the Department to the hospital in which it is notified of the outpatient reimbursement settlement.

*Adjustment Procedure:* The Department will recalculate the disproportionate share payment limitation under §5248 taking into account the outpatient reimbursement settlement.

**P. Claim Adjustment For Length Of Stay Outlier**

*Qualifying Determination:* For any stay which meets the criteria of §5330, a hospital may request a calculation of a length of stay outlier payment adjustment.

*Adjustment Procedure:* The hospital must submit a claim for the stay to the Department's fiscal agent. The hospital must also submit a request for this administrative adjustment to the Department with a copy of the claim. The Department will determine if the claim qualifies for an adjustment and will calculate the amount of adjustment.

Hospitals should send requests for a length of stay outlier adjustment to: Division of Health Care Access and Accountability, P. O. Box 309, Madison, WI 53701-0309.

*Request Due Date:* The request for this adjustment must be delivered to the Department within 180 days after the date the recipient is discharged from the hospital. This due date applies without regard as to whether or not a claim for the stay has been paid by the Department's fiscal agent.

**Q. Adjustment For Hospital Expecting Payment To Exceed Charges**

*Qualifying Criteria:* Section 9000 requires a retroactive recovery of payments when a hospital's overall payments for MA recipient services exceeds charges-plus-disproportionate share, in aggregate, for each state fiscal year period of July 1 through June 30. A hospital may request an interim decrease of its payment rate in order to avoid a significant recovery which it expects may result from accepting payment at its full allowed payment rate.

*Continuation -- Payments to Exceed Charges*

**Adjustment Procedure:** An interim payment rate will be established at a rate mutually agreeable to the hospital and the Department. After completion of the state fiscal year a final reimbursement settlement will be calculated. The charge limitation of \$9000 will be applied using overall payments including payments at the interim rates. If the payments exceed the charges, the excess will be recouped. If the payments are less than charges, then the charge limitation of \$9000 will be applied using overall payments calculated at the hospital's full allowed payment rate. The lesser of payments (a) at the full allowed rate, or (b) charges-plus-disproportionate share will be the final allowed reimbursement for the year. An additional payment will be made for the difference between the interim reimbursement and the final allowed reimbursement.

**Request Due Date and Effective Date:** This adjustment may be requested at any time with the interim payment rate effective prospectively.

**R. Disproportionate Share Adjustment for New Hospital**

**Qualifying Determination:** This administrative adjustment allows a new hospital to receive a disproportionate share adjustment for its initial years of operation to be based on its Medicaid inpatient day utilization for periods other than base cost report period specified in §5243.

**Request Due Date and Effective Date:** The 60 day rule per §11600 applies.

**Expiration of Adjustment:** The DSH adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. The hospital must submit a new request for this adjustment for each rate year which begins each July 1st. (Reference §11500.)

**Definitions:** A new hospital's "initial years of operation" begin the date the hospital admits its first WMAP recipient and ends the June 30th date following completion of the hospital's fourth full fiscal year after the fiscal year in which the first WMAP recipient was admitted. (For example, a hospital's fiscal year ends each December. It admitted its first WMAP recipient on May 9, 1994. Its fourth full fiscal year after the admission ends December 31, 1998. Its "initial years of operation" end June 30, 1999.)

**Adjustment Procedure:** The DSH adjustment will be determined according to §5240. For a "Medicaid utilization adjustment", the number of inpatient days for the calculation will not come from the base cost report specified in §5243. The first adjustment which a hospital requests will be based on inpatient day data from a period of at least six months which may begin before the facility was certified for the WMAP and before the first WMAP recipient was admitted but may not begin before the facility was licensed as a hospital. Disproportionate share adjustments for subsequent rate years (i.e., rate years after the rate year in which the first DSH adjustment was made) will be based on inpatient day data for an updated and more current period of at least six months.

The specific data reporting periods to be used will be specified by the Department after consultation with the hospital. The data may be audited at a later date and, if found to be in error, the Department will recover any overpayment that resulted.

**S. Adjustment for Combining Hospitals**

Sections 5860 and 6460 provide that, for recent hospital combinations, costs and patient days from the audited cost reports of each previous individual (i.e., before combining) hospital will be combined to calculate those components of the hospital payment rates which require the use of cost report data. Hospital combinations result from hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. Audited cost reports for the individual hospitals will be used until an audited cost report for the combined or absorbing hospital becomes available for the annual rate update. This administrative adjustment allows the combined or absorbing hospital to have its payments retroactively adjusted based on its audited cost report when they become available.

*Continuation -- Combining Hospitals*

**Qualifying Criteria:** The combined or absorbing hospital had those components of its payment rates which require cost report data based on the costs and patient days from the audited cost reports of the previous individual hospitals as provided in sections 5860 and 6460.

**Request Due Date and Effective Date:** The 60 day rule applies per §11600 above. The 60 day period applies to the notification of those rates which are based on the costs and patient days from the audited cost reports of each previous individual hospital.

For example, hospitals A and B merged into hospital C on May 1, 1995 with C having a December fiscal year end. Hospital C is notified by the Department on May 10, 1995 of its payment rates which are based on the audited cost reports of A and B. The 60 day rule starts with this May 10th notification in order for the hospital to request its rates to be retroactively adjusted based on its audited cost report for its fiscal year ending December 31, 1995 when the audited cost report becomes available.

**Expiration of Request:** The initial request will cover all periods during which payment rates were based on the audited cost reports of the previous hospitals. (Section 11500 above does not apply to this adjustment.) The hospital may withdraw the request according to the provisions §11300.

**Adjustment:** When the merged or absorbing hospital's audited cost reports become available to the Department, the Department will recalculate those payment rate components which were based on the audited cost reports of the previous hospitals and which were in effect during the period of the merged or absorbing hospital's audited cost report. Based on the recalculated payment rates, a payout or recoupment will be made for the WMAP recipient services provided by the hospital during the cost report period.

For example, hospital C's audited cost report for its first fiscal year, May 1 through December 31, 1995, became available in April 1996. Its payments for May through December 1995 will be retroactively adjusted based on this audited cost report even though it spans two WMAP rate years. (Also, because this audited cost report was received in April 1996, it will be used for the July 1, 1996 annual rate update and the use of previous hospitals' cost reports will be discontinued.)

END OF SECTION 11000  
ADMINISTRATIVE ADJUSTMENT ACTIONS





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Wisconsin Medicaid Program  
Inpatient Hospital State Plan  
Under Title XIX of the Social Security Act

Methods and Standards for Determining Payment Rates

\*\*\*\*\* **APPENDICES** \*\*\*\*\*

- 21000 LISTING OFF HOSPITALS EXEMPT FROM CAPITAL REDUCTION
- 22000 EXAMPLE CALCULATION HOSPITAL SPECIFIC DRG BASE RATE
- 23000 EXAMPLE CALCULATION MONTHLY CAPITAL PAYMENT
- 24000 EXAMPLE CALCULATION MONTHLY GRADUATION MEDICAL  
EDUCATION PAYMENT
- 24500 EXAMPLE CALCULATION COST OUTLIER PAYMENT
- 25000 EXAMPLE CALCULATION SAFETY NET
- 26000 EXAMPLE CALCULATION HOLD HARMLESS
- 27000 AREA WAGE INDICES
- 27100 DISPROPORTIONATE SHARE ADJUSTMENT AMOUNTS
- 27200 INFLATION MULTIPLIERS FOR ADMINISTRATIVE ADJUSTMENTS
- 28000 PROCEDURES FOR ADMINISTRATIVE ADJUSTMENT
- 29000 MEDICARE EXEMPT PSYCHIATRIC UNITS

**APPENDIX SECTION 21000**

**LISTING OF  
HOSPITALS QUALIFYING FOR EXEMPTION FROM CAPITAL COST REDUCTION  
OF SECTION 5430, ITEM 2  
AS OF JULY 1, 2006**

This list can change whenever a hospital demonstrates it meets the qualifying criteria  
or when a hospital no longer meets the qualifying criteria

**Hospital & Location**

Memorial Medical Center .....	Ashland
Bay Area Medical Center .....	Marinette
St. Joseph's Hospital.....	Marshfield
Hess Memorial Hospital .....	Mauston
St. Clare Hospital .....	Monroe
St. Mary's Hospital .....	Rhineland
Howard Young Medical Center.....	Woodruff
Riverview Hospital.....	Wisconsin Rapids

22000 Example Calculation - Hospital Specific DRG Base Rate

**APPENDIX SECTION 22000**  
**EXAMPLE CALCULATION**  
**HOSPITAL-SPECIFIC DRG BASE RATE**

	Wage Portion	Non-Wage Portion	Total
1. Base DRG Rate .....	\$ 3,126	\$ 3,126	
2. X Wage Differentials .....	0.7495	0.2505	
3. = Wage Portion of Base Rate .....	\$ 2,343		
4. X Wage Area Index.....	0.9858		
5a. = Adjusted Wage Portion .....	\$ 2,310		
5b. = Non-Wage Portion of Base Rate.....		\$ 783	
6. Total of Adjusted Wage & Non-Wage .....			\$ 3,093
7. Not used			
8. X Disproportionate Share Factor (Note A) .....			1.0430
9. X Rural Hospital Adjustment (Note A).....			1.1500
10. = DRG Base Rate before Capital and Direct Medical Education .....			\$ 3,710
11. Add: Hospital-Specific Base Capital Payment.....			\$ 528
12. Add: Hospital-Specific Base Direct Medical Education Payment .....			\$ 70
			See Note B below
13. <b>HOSPITAL-SPECIFIC DRG BASE RATE .....</b>			<b>\$ 4,308</b>
<b>including capital and direct medical education base payment</b>			

Note A -- If no adjustment applies to hospital, then a 1.00 multiplier is used

Note B -- For rate year July 1, 2003 through June 30, 2004, the direct medical education payment illustrated above is multiplied by a budget reduction factor of .286. For the example above, \$70 multiplied by .286 provides a \$20 direct medical education payment at line 12 and a \$4,258 total hospital-specific rate at line 13.

23000 Example Calculation – Base Capital Payment

**APPENDIX SECTION 23000**

**EXAMPLE CALCULATION**

**HOSPITAL-SPECIFIC BASE CAPITAL PAYMENT  
For Wisconsin Hospitals and Major Border Status Hospitals**

CAPITAL COSTS. ....	\$ 1,558,800	
(Cost Report Source: Worksheet B part II line 95 minus costs not related to hospital, lines 34-36 and 63-94)		
Divide by: TOTAL COSTS. ....	Divide by	\$23,908,575
(Cost Report Source: Worksheet C line 101 minus lines 34-36 and 63-94)		
RATIO CAPITAL COSTS TO TOTAL COSTS. ....	=	0.0652
TOTAL T-19 INPATIENT COSTS. ....	X	\$ 1,663,287
(Cost Report Source: Supplemental worksheet E-3 part III line 1)		
T-19 CAPITAL COSTS .....	=	\$ 108,446
		\$ 108,446
CAPITAL REDUCTION FACTOR (5% used for purpose of example). ....	X	5%
CAPITAL REDUCTION AMOUNT. ....	=	( \$ 5,442)
REDUCED T-19 CAPITAL COSTS .....	=	\$ 103,004
DRI INFLATION FACTOR. ....	X	1.192
REDUCED CAPITAL X DRI FACTOR. ....	=	\$ 122,781
DISPROPORTIONATE SHARE FACTOR .....	X	1.043
CAPITAL With DISPROPORTIONATE SHARE ADJUSTMENT .....	=	\$ 128,061
WMP RECIPIENT DISCHARGES from audited cost report .....	Divide by	196
CAPITAL COST PER DISCHARGE .....	=	\$ 653
AVERAGE DRG CASE MIX WEIGHT (INDEX) PER DISCHARGE. ....	Divide by	1.2370
<b>HOSPITAL-SPECIFIC BASE CAPITAL PAYMENT .....</b>	<b>=</b>	<b>\$ 528</b>

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used



**APPENDIX SECTION 24000  
EXAMPLE CALCULATION**

**HOSPITAL-SPECIFIC BASE DIRECT MEDICAL EDUCATION PAYMENT  
For Wisconsin Hospitals**

ROUTINE & SPECIAL CARE COST, MEDICAL EDUCATION COSTS. ....	\$70,475
(Cost Report Source: Worksheet D part 1 line 101, column 3, medical education costs)	
ANCILLARY MEDICAL EDUCATION COSTS. ....	+ \$125,051
(Cost Report Source: Worksheet D part II line 101, column 3, medical education costs)	
TOTAL MEDICAL EDUCATION COSTS .....	= \$ 195,526
TOTAL COSTS. ....	Divide by \$23,908,575
(Cost Report Source: Worksheet C line 101 minus lines 34 to 36 and 63 to 94)	
RATIO MEDICAL EDUCATION COSTS TO TOTAL COSTS. ....	= .0082
TOTAL T-19 INPATIENT COSTS .....	X \$1,663,287
(Cost Report Source: Supplemental worksheet E-3 part III line 1)	
T-19 DIRECT MEDICAL EDUCATION COSTS .....	= \$13,639
DRI INFLATION FACTOR. ....	X 1.192
INFLATED DIRECT MEDICAL EDUCATION COSTS .....	= 16,258
DISPROPORTIONATE SHARE FACTOR (Note A). ....	X 1.043
ADJUSTED FOR DISPROPORTIONATE SHARE. ....	= \$16,957
WMP RECIPIENT DISCHARGES from audited cost report .....	Divide by 196
DIRECT MEDICAL EDUCATION PROGRAM COST PER DISCHARGE .....	= \$ 87
AVERAGE DRG CASE MIX WEIGHT (INDEX) PER DISCHARGE. ....	Divide by 1.2370
<b>HOSPITAL-SPECIFIC BASE DIRECT MEDICAL EDUCATION PAYMENT .....</b>	<b>= \$ 70</b>
See Note B below	

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used

Note B --The direct medical education payment illustrated above is multiplied by a budget reduction factor of 1.00. For the example above, \$70 is multiplied by . 1.00 providing a \$70 direct medical education payment.



24500 Example Calculation - Cost Outlier Payment

**APPENDIX SECTION 24500**

**EXAMPLE CALCULATION  
COST OUTLIER PAYMENT**  
Pursuant to Section 5320

BASE DATA

APPROVED BEDS .....	42
T-19 INPATIENT COSTS (Cost Report Source: Worksheet E-3 part III line 1) ..	\$1,663,287
T-19 INPATIENT CHARGES (Cost Report Source: Worksheet E-3 part III line 21) Divide by	\$2,099,050
COST-TO-CHARGE RATIO FOR OUTLIER CALCULATIONS .....	= 0.7924
(Ratio of T-19 inpatient costs to T-19 inpatient charges)	

EXAMPLE CALCULATION OF COST OUTLIER PAYMENT

1.	Allowable claim charges.....	\$ 73,550
2.	Cost-to-charge ratio (see above) .....	X .7924
3.	Claim charges adjusted to cost.....	\$ 58,281.02
4.	DRG Payment.....	(\$ 12,477.10)
5.	Claim cost exceeding DRG payment .....	\$ 45,803.92
6.	Applicable trimpoint for hospital bed size .....	(\$ 5,235)
(Trimpoints applicable to current rate year are listed in section 5320.1.)		
7.	Decision: Does Line 5 -exceed- Hospitals Trimpoint at Line 6?	
	x Yes - Continue at Line 8	
	No - No outlier payment in addition to DRG payment	
8.	Claim cost exceeding DRG payment and trimpoint.....	= \$ 40,568.92
9.	Variable cost factor.....	.77
10.	Disproportionate share adjustment percentage (Note A) .	X 1.043
11.	Adjusted variable cost factor.....	X .8031
12.	OUTLIER PAYMENT .....	= \$ 32,580.90
13.	DRG PAYMENT .....	+ \$ 12,477.10
14.	TOTAL PAYMENT FOR CLAIM including outlier payment .....	\$ 45,058.00

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used

For Line 4 above, example calculation of base DRG payment.

	Basic DRG	Capital	Direct Med Ed	Total
Hospital-Specific Base Rate	\$ 3,832	\$ 528	\$ 70	\$ 4,430
Times: DRG Weight for stay	2.8165	2.8165	2.8165	2.8165
Basic DRG Payment	\$ 10,792.83	\$ 1,487.11	\$ 197.16	\$ 12,477.10

**APPENDIX SECTION 27000**  
**AREA WAGE INDICES**  
Effective July 1, 2006

The following wage area indices are based on hospital hours and salaries for hospital fiscal years that began in federal fiscal year October 2001 through September 2002. The methodology for calculating these indices is described in Section 5220, entitled "Wage Area Adjustment Index".

WAGE AREAS FOR WISCONSIN HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Appleton	.9384	None
Eau Claire	.9313 (Note A)	None
Fond du Lac (Includes Green Lake County, WI, Note B)	.9313 (Note A)	None
Green Bay	.9581	None
Janesville/Beloit	.9443	None
Kenosha	All hospitals reclassified to Chicago for .9904 index	
La Crosse	.9662	None
Madison (Includes Green County, WI, Note B)	1.0703	.9759
Milwaukee County	1.0363	None
Ozaukee-Washington-Waukesha Counties (Includes Dodge County & Jefferson County, WI, Note B)	1.0125	.9516
Oshkosh-Neenah		None
Racine.....All hospitals reclassified to Ozaukee-Washington-Waukesha Counties for .9516 index		
Sheboygan	.9313 (Note A)	None
Superior, WI / Duluth, MN	1.0435	None
Wausau	1.0037	1.0037
Rural Wisconsin	.9313	None

*Note A – Section 5224, page 9, requires that “the index applied to any hospital located in Wisconsin shall not be lesser than the rural Wisconsin index.” The rural Wisconsin index is .9313.*

*Note B – These rural counties were re-designated to the urban area pursuant to section 1886(d)(8)(B) of the Social Security Act. These are often referred to as ‘Lugar counties’.*

WAGE AREAS FOR BORDER STATUS HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Twin Cities, Minnesota . . . . . (St. Paul, Minneapolis, Coon Rapids, Edina, Lake City, Robinsdale, Stillwater, Chisago City, Hasting) .....	1.1166	1.1166
Duluth, Minnesota . . . . .	1.0435	None
Rochester, Minnesota . . . . .	1.1253	None
Rockford, Illinois . . . . .	1.0087	None
Dubuque, Iowa . . . . .	.9117	None
Chicago —(Includes Walworth County, WI, Note B) .	1.0657	.9904
Iowa City, Iowa . . . . .	.9799	None
Rural Illinois . . . . .	.8825	None
Rural Minnesota . . . . .	.7985	None
Rural Michigan . . . . .	.8934	None

**APPENDIX SECTION 27100  
DISPROPORTIONATE SHARE ADJUSTMENT AMOUNTS**

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**FOR SECTION 5243, MEDICAID UTILIZATION METHOD**

A hospital's disproportionate share adjustment factor under section 5180 5243 is calculated according to the following formula where:

- S % = Medicaid inpatient utilization rate at one standard deviation above the statewide mean Medicaid utilization rate.
- M = The hospital's Medicaid inpatient utilization rate for hospitals with a utilization rate greater than S%.
- .26 = Linear slope factor allowing proportional increase in disproportionate share adjustment as utilization rate (M) increases.

Formula:

$$[(M - S\%) \times .26] + 3\% = \text{Hospital's Specific Disproportionate Share Adjustment Percentage for section 5243}$$

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**FOR SECTION 8100, THE ESSENTIAL ACCESS CITY HOSPITAL (EACH)  
DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT**

**Annual Statewide Funding**

The annual statewide funding for the essential access city hospital (EACH) disproportionate share hospital adjustment is \$4,748,000.

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**FOR SECTION 8300, THE GENERAL ASSISTANCE DISPROPORTION SHARE HOSPITAL ALLOWANCE**

**Maximum Available Funding**

For the rate year July 1, 2008 through June 30, 2009, the maximum available funding for the general assistance disproportionate share hospital allowance (GA-DSH) under section 8200 is an amount not to exceed \$75,000,000.

**APPENDIX 27200  
INFLATION RATE MULTIPLIERS  
FOR ADMINISTRATIVE ADJUSTMENTS  
FOR RATES EFFECTIVE JULY 1, 2006 THROUGH JUNE 30, 2007**

Inflation rates to be applied in calculating the following administrative adjustments of §11900:

Item B -- Capital and direct medical education payment based on cost  
report more than three years old

Item C -- Capital payment adjustment for major capitalized expenditures

Item D -- Adjustment for changes in medical education

Month Fiscal Year Inflation Ended Multiplier	Month Fiscal Year Ended Inflation Multiplier	Month Fiscal Year Ended Inflation Multiplier
2000	2003	2006
Jan-2000 ..... 1.3284	Jan-2003 ..... 1.1746	Jan-2006 ..... 1.0405
Feb-2000 ..... 1.3284	Feb-2003 ..... 1.1746	Feb-2006 ..... 1.0405
Mar-2000 ..... 1.3284	Mar-2003 ..... 1.1746	Mar-2006 ..... 1.0405
Apr-2000 ..... 1.3163	Apr-2003 ..... 1.1688	Apr-2006 ..... 1.0337
May-2000 ..... 1.3163	May-2003 ..... 1.1688	May-2006 ..... 1.0337
Jun-2000 ..... 1.3163	Jun-2003 ..... 1.1688	Jun-2006 ..... 1.0337
Jul-2000 ..... 1.2996	Jul-2003 ..... 1.1566	Jul-2006 ..... 1.0235
Aug-2000 ..... 1.2996	Aug-2003 ..... 1.1566	Aug-2006 ..... 1.0235
Sep-2000 ..... 1.2996	Sep-2003 ..... 1.1566	Sep-2006 ..... 1.0235
Oct-2000 ..... 1.2880	Oct-2003 ..... 1.1483	Oct-2006 ..... 1.0155
Nov-2000 ..... 1.2880	Nov-2003 ..... 1.1483	Nov-2006 ..... 1.0155
Dec-2000 ..... 1.2880	Dec-2003 ..... 1.1483	Dec-2006 ..... 1.0155
2001	2004	2007
Jan-2001 ..... 1.2710	Jan-2004 ..... 1.1339	Jan-2007 ..... 1.0077
Feb-2001 ..... 1.2710	Feb-2004 ..... 1.1339	Feb-2007 ..... 1.0077
Mar-2001 ..... 1.2710	Mar-2004 ..... 1.1339	Mar-2007 ..... 1.0077
Apr-2001 ..... 1.2565	Apr-2004 ..... 1.1224	Apr-2007 ..... 1.0000
May-2001 ..... 1.2565	May-2004 ..... 1.1224	May-2007 ..... 1.0000
Jun-2001 ..... 1.2565	Jun-2004 ..... 1.1224	Jun-2007 ..... 1.0000
Jul-2001 ..... 1.2457	Jul-2004 ..... 1.1077	Jul-2007 ..... .9904
Aug-2001 ..... 1.2457	Aug-2004 ..... 1.1077	Aug-2007 ..... .9904
Sep-2001 ..... 1.2457	Sep-2004 ..... 1.1077	Sep-2007 ..... .9904
Oct-2001 ..... 1.2371	Oct-2004 ..... 1.0984	Oct-2007 ..... .9829
Nov-2001 ..... 1.2371	Nov-2004 ..... 1.0984	Nov-2007 ..... .9829
Dec-2001 ..... 1.2371	Dec-2004 ..... 1.0984	Dec-2007 ..... .9829
2002	2005	2008
Jan-2002 ..... 1.2266	Jan-2005 ..... 1.0860	Jan-2008 ..... .9743
Feb-2002 ..... 1.2266	Feb-2005 ..... 1.0860	Feb-2008 ..... .9743
Mar-2002 ..... 1.2266	Mar-2005 ..... 1.0860	Mar-2008 ..... .9743
Apr-2002 ..... 1.2162	Apr-2005 ..... 1.0778	
May-2002 ..... 1.2162	May-2005 ..... 1.0778	
Jun-2002 ..... 1.2162	Jun-2005 ..... 1.0778	
Jul-2002 ..... 1.2020	Jul-2005 ..... 1.0651	
Aug-2002 ..... 1.2020	Aug-2005 ..... 1.0651	
Sep-2002 ..... 1.2020	Sep-2005 ..... 1.0651	
Oct-2002 ..... 1.1911	Oct-2005 ..... 1.0496	
Nov-2002 ..... 1.1911	Nov-2005 ..... 1.0496	
Dec-2002 ..... 1.1911	Dec-2005 ..... 1.0496	

**Example Use of Table**

Costs from a fiscal year ended September 2003 are inflated to the rate year ending June 2007 by applying the above 1.1566 multiplier to the costs. For a fiscal year ended December 2005, apply the 1.0496 multiplier to costs

## APPENDIX SECTION 27300

### RURAL HOSPITAL ADJUSTMENT PERCENTAGES PURSUANT TO SECTION 5260

The following table lists the the rural hospital adjustment percentages that are applied under section 5260. The rural hospital adjustment percentage is that percentage corresponding to the range of utilization percentages in which the individual hospital's Medicaid utilization rate falls. For example, a Medicaid utilization rate of 7.34% falls in the "5.0% through 9.99%" range that has a corresponding 11% rural hospital percentage. Similarly, a 11.23% utilization rate corresponds to a 17% rural hospital percentage.

#### EFFECTIVE ON and AFTER JULY 1, 2001

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%.....	5.00%
5.0% through 9.99% .....	11.00%
10.0% through 14.99% .....	17.00%
15.0% and greater .....	23.00%

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#### EFFECTIVE JULY 1, 2000 THROUGH JUNE 30, 2001

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%.....	8.00%
5.0% through 9.99% .....	17.00%
10.0% through 14.99% .....	26.00%
15.0% and greater .....	35.00%



## **APPENDIX 28000**

### **PROCEDURES FOR PROCESSING ADMINISTRATIVE ADJUSTMENTS**

#### **For Inpatient and Outpatient Hospital Payments**

The Department provides an administrative adjustment procedure that allows individual hospitals an opportunity to receive a prompt review of their payment rates for specific circumstances. The policies and criteria for administrative adjustments that apply to hospitals are provided in the following State Plan sections:

- (1) For inpatient rates for hospitals in Wisconsin and major border status hospitals, see §11000 of the "Inpatient Hospital State Plan",
- (2) For inpatient rates for minor border status hospitals and out-of-state hospitals, see §10400 of the "Inpatient Hospital State Plan",
- (3) For outpatient rates, see §6000 of the "Outpatient Hospital State Plan".

This appendix outlines the procedures the Hospitals, Physicians and Clinics staff of the Division (we) will follow for processing administrative adjustment requests from hospitals. Under some circumstances, an interim administrative adjustment may be provided with a final adjustment calculated after a required audited cost report is available. The procedures in this appendix apply to the calculation of interim and final administrative adjustments.

These procedures apply to any administrative adjustment request submitted by a hospital on and after July 1, 1996.

#### **28010 Receipt of Request For Administrative Adjustment**

A request for an administrative adjustment must meet the following requirements:

- (1) *The request must be submitted by the due date.* A due date is specified in the state plan sections listed above for each circumstance for which an adjustment may be requested.
- (2) *The request must be sufficient.* The request must inform us:
  - (a) as to whether the request applies to inpatient or outpatient rates,
  - (b) the specific circumstance listed in the state plan for which the hospital is requesting an adjustment, and
  - (c) the effective date of the rate to be adjusted or the outpatient final settlement period to be adjusted.

Upon receipt of a request for an administrative adjustment, we will review the request and, if necessary, contact the hospital regarding the following items:

- (1) We will determine if the request was submitted by the due date. If not, we will notify the hospital either:
  - (a) if the request is denied because it has not been submitted by the required due date, or
  - (b) if "the 60 day rule" allows the adjustment to be effective at some date other than the effective date of the rate for which an adjustment is being requested. (The "60 day rule" is described in §11600 of the "Inpatient Hospital State Plan" and §6300 of the "Outpatient Hospital State Plan".)
- (2) We will determine if the request is sufficiently clear. If not, we will contact the hospital for clarification and may ask the hospital to resubmit a sufficient request.
- (3) We will assess the data needed to calculate the adjustment. If additional data is needed from the hospital, we will request additional data according to the procedure described in §28020 below.

### **28020 Request For Additional Data**

If we determine additional data is needed for the adjustment, we will contact the hospital to request the additional data and specify a due date for the hospital to submit it. The due date we specify will not be less than one month and not more than three months from the date of our request. However, if the hospital requests an extension and can justify that additional time is needed to provide accurate information, we may allow additional time for submitting the data.

If the hospital does not submit the data or an extension request within the specified time period, we will notify the hospital in writing that the administrative adjustment will be denied unless the hospital submits the requested data. With this notice, we will specify another due date for submitting the data of not less than two weeks and not more than one month from the date of this notice.

In order to calculate the administrative adjustment, we may find it necessary to request additional data more than once from the hospital. Each request for additional data will be handled as outlined above.

### **28030 Notification to the Hospital of Our Proposed Adjustment**

After we have the needed data, we will calculate the adjustment and send a notification to the hospital of our proposed adjustment along with supporting worksheets.

We will request the hospital to review our proposed adjustment and respond only if the hospital disagrees with the calculations. We will specify a due date for a response of not less than one month and not more than three months from the date of our notification to the hospital of the proposed adjustment.

If the hospital responds with a disagreement to our calculations, we will attempt to settle the disagreement with the hospital as described in §28040 below.

If we do not receive a response from the hospital by the due date, we will deem our proposed adjustment accepted by the hospital and we will adjust the hospital's payment accordingly.

### **28040 If Hospital Disagrees With Our Proposed Administrative Adjustment**

If the hospital disagrees with our proposed administrative adjustment, we will attempt to settle any disputes the hospital may have and reach an agreement. The process of settling disputes may continue until a mutual agreement is reached. It may involve our revising the adjustment one or more times. In the process of settling disputes, we may request additional data according to the procedures outlined in §28020 above.

#### ***28041 If We Do Not Revise the Disputed Adjustment.***

If we do not revise the disputed adjustment, we will notify the hospital that no change will be made to the previously proposed adjustment. In this notification, we will inform the hospital that they can request a meeting with the administrative adjustment review panel and that such a request must be submitted by a due date that we will specify. (The panel is described in §28050 below.) The specified due date will not be less than one month and not more than three months from the date of this notice.



If we do not receive a request for a meeting from the hospital by the due date, we will deem our proposed adjustment accepted by the hospital and we will adjust the hospital's payment accordingly.

If the hospital requests a meeting with the review panel, we will contact the hospital to schedule a meeting.

We will not schedule a meeting with the administrative adjustment review panel until the hospital and us have attempted to reach an agreement on a disputed adjustment. We will schedule a meeting at the hospital's request only after the hospital has submitted a disagreement to our initial or first adjustment proposal and: (a) we have either responded to the hospital with at least one revised adjustment which they do not accept, or (b) we have notified the hospital that we will not change the proposed adjustment.

*28042 If We Revise a Disputed Adjustment.*

If we revise a disputed adjustment, we will send our revised adjustment and supporting worksheets to the hospital. With our proposing a revised adjustment, the procedures described in §24030 and §24040 above will be used for notifying the hospital and handling any disputes the hospital may have with the revision.

**28050 Administrative Adjustment Review Panel**

The administrative adjustment review panel serves as an advisory group to the administrator of the Division of Health Care Access and Accountability (DHCAA) for final decisions on disputed administrative adjustments. The panel will be chaired by a designee of the administrator and will consist of at least four other staff of the DHCAA. Panel members will be appointed by the administrator or his/her designee and will not necessarily be the same persons for each meeting or case. Up to two staff persons who are directly involved in hospital rate setting may be, but need not be, on the review panel. The staff person or persons who calculated the adjustment will not be on the review panel.

Meetings of the review panel will be scheduled with hospital consultation. The hospital's representatives may attend the meeting in person or may meet with the panel through a teleconference. In addition to meeting with the panel, the hospital's representatives may provide written position papers and other information regarding their case.

The meeting will be an informal fact finding meeting under the control and direction of the chairperson of the review panel. The DHCAA staff person(s) who calculated the adjustment will explain their calculations and policy considerations and answer inquiries from the panel and from the hospital's representatives. The hospital's representatives will be given the opportunity to present the hospital's case and answer inquiries from the panel members and from the DHCAA staff person(s) who calculated the adjustment. After hearing the presentations, the review panel will develop a recommendation for the administrator of the DHCAA, which may include or be based on a revised calculation prepared at the direction of the panel. The panel may discuss the case without the presence of the hospital's representatives.

The DHCAA administrator or his/her designee will make the final decision on the adjustment and will send notice of the decision to the hospital.

*End of Administrative Adjustment Procedures.*

**End of Inpatient Hospital State Plan**